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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

Date: X; Amendment X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned Disagree

☒ Partially Overturned Agree in part/Disagree in part

☐ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. While X was on X way to home health patient's home, X stopped at a red light, when a vehicle rear-ended X and pushed X into the vehicle in front of X causing injuries to X lower back, right hip and right side of the neck. The diagnoses were strain of lumbar spine (X), strain of right hip (X), acute lumbar radiculopathy (X) and cervical strain (X).X was seen by X, MD on X for a re-evaluation with respect to a work-related injury sustained while working on X. X presented for a follow-up of right hip injury. The pain was rated 6/10. X was able to do X. X had constant pain, which worsened by sitting. Standing made it better. X had no new symptoms except hip and low back pain radiating to right lower extremity. X was following the treatment plan, but it was not really helping. X was on X. X had multiple sessions of X. On examination, flexion, extension, and rotation of the lumbosacral spine was X. X was X. X was grossly intact in the lower extremity. X was X. X were noted at X. X was noted on palpation. X had positive X. An appeal for X was requested. X was requested as X was very anxious. X visited X, MD on X for a follow-up of right hip injury. X was off work at the time and had no light duty available. The pain was rated X. X was taking X. X felt worse, dull and throbbing pain. The pain worsened by sitting. Lying down made the pain better. The pain went up the back. The treatment plan was not helping. X was on X. X had been X without any improvement. Spine surgery evaluation concurred that X needed an X. Examination of the low back revealed flexion, extension and rotation of the lumbosacral spine decreased by X. X was X. X were noted. X was equivocal on the right. X

was equivocal on the right. There was right X. Dr. X opined that at the point, X would appeal to IRO. As far as the right X was concerned, the only other thing that would be able to be offered was a X, which was denied and X was uncertain that X wanted to participate in that. X consulted X, MD on X for the evaluation of back pain. X still had back and right leg pain. Examination of the lumbar spine showed X. There was X secondary to the pain. X was X. X was intact to light touch throughout except the lateral aspect of the right foot, which was slightly decreased. An MRI X in X, but there were X. A CT scan did show there was a X. X continued to have symptoms of which X was awaiting X. Dr. X agreed with Dr. X that the X would help. There were no surgical indications at the time. An MRI of the lumbar spine dated X revealed following findings: there were X. There was X. There was no associated X. An MRI of the right hip dated X demonstrated X. The right X. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the concurrent request for X was non-certified. Rationale: “Based on the documents, the claimant sustained an injury from a motor vehicular accident. They were diagnosed with a strain of muscle, fascia, and tendon of the right hip. The claimant was on modified duty. Prior treatments included X. According to the progress report submitted by X, MD on X, the claimant presented with low back pain, and right-sided hip pain rated X. Their pain was described as dull, and throbbing. Sitting and bending were noted to make the pain worse. Lying down alleviated the pain. Upon examination, the toe and heel were good. Flexion, extension, and rotation of the lumbosacral spine decreased by X. X was X. Regarding X, the Official Disability Guidelines state that X is not recommended for X. Based on the provided documentation, the request is not supported by guidelines at this time. The claimant was diagnosed with a strain of muscle, fascia, and tendon of the right hip. The cited guideline does not support the treatment request. Given the above information, the concurrent request for X is non-certified. “Per a reconsideration

utilization review adverse determination letter dated X by X, MD, the prospective request for X was non-certified. Rationale: The prior non-certification in review X. The provider, X, M.D., submitted an appeal letter dated X for the denial of X. According to the submitted documentation, the claimant sustained an injury from a motor vehicle accident. The claimant was diagnosed with a strain of muscle, fascia, and tendon of the right hip and lower back and person injured with unspecified motor vehicle accident. The claimant was on modified duty. The attempted treatments included X. They had a history of X. A CT scan of the lumbar spine dated X revealed X was identified. An x-ray of the lumbar spine dated X. An MRI of the right hip dated X revealed there was X. The X. There was X. A X were noted. An MRI of the lumbar spine dated X revealed there were X. No X was identified and there was X. Per the most recent available progress report dated X and submitted by X, M.D., the claimant presented with complaints of low back pain and right sided hip pain and was rated at X. They were able to do about X. The pain was described as dull, throbbing, and numb associated with radiating pain. Their pain was made worse with sitting and bending, and lying down made it better. Examination revealed toe and heel walking was good. The flexion, extension, and rotation of the lumbosacral spine X. X was X. The provider is appealing the prior determination at this time. Regarding X, the Official Disability Guidelines state that it is recommended on a case-by-case basis as X. This is a condition that is generally considered rheumatologic in origin. X is not generally recommended. When required for extreme anxiety, a patient should remain alert enough to reasonably converse. Upon review of the submitted records, it appears that the prior non-certification was appropriate. Per the submitted documentation, the claimant presented with low back pain and right sided hip pain associated with numbness, radiating pain, X. The CT scan of the right hip showed X. The MRI findings of the lumbar spine revealed X. The referenced guideline states that X is recommended for pain that is generally considered rheumatologic in

origin. Per cited guidelines and the claimant's clinical presentation, the request is not supported for X. In addition, there were no signs of extreme anxiety that would warrant X. Therefore, the appeal request for X is non-certified. "Thoroughly reviewed provided records including peer reviews and imaging findings. Patient appears to have X. Patient failed X. Reviewers cite ODG criteria for X. However, given that pain in X is warranted. On the other hand, no documentation explains request for X and is thus not warranted. X is medically necessary and certified and request for X is not medically necessary and non certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Thoroughly reviewed provided records including peer reviews and imaging findings. Patient appears to have X. Patient X. Reviewers cite ODG criteria for X. However, given that pain in X , requested procedure is warranted. On the other hand, no documentation explains request for X and is thus not warranted. X is medically necessary and certified and request for X is not medically necessary and non certified.

Partially Overturned

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL