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An Independent Review Organization
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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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. X stated X worked in X. The diagnosis was sprain of ligaments of lumbar spine, initial encounter (S33.5XXA).On X was evaluated by X, MD. X complained of low back pain. The pain radiated into the left lower extremity. The pain had been going on for several months. The pain onset was associated with a work-related injury. The pain felt like constant aching pain, throbbing, burning and shooting pain down the left leg. X reported that X was able to stand for less than X minutes; able to walk for less than X minutes with a X and able to sit for more than X minutes. At the time, X rated pain X; at the worst was X and at best was X. An MRI of lumbar spine was X. X underwent X. The pain was made better by nothing. The pain was made worse by standing, sitting and walking. X was working as full duty. Numbness, weakness, and tingling were noted in the left lower extremity. Sleep was disturbed frequently by pain and was poor. Mood was discouraged. On examination, blood pressure was 150/75 mmHg. Lumbar spine examination revealed poor toe walking; and poor heel walking on the left. Lower extremities motor strength was X on the right and X on the left. Sensory deficit in the X was noted. There was X. X was X. X was requested at X. This would be followed by X. X communicated a willingness for X. X had a degree of X. X understood that it was important to minimize sudden movement during the procedure. X expressed a X. On X, X was evaluated by Dr. X for a follow-up visit. X reported there was no significant changes since the prior visit. There was worsening of pain noted. The pain level was rated X at the time, X at the worst and X at best. There was constant radiation into the left lower extremity. X stated

that the pain felt like constant aching pain, throbbing, burning and shooting pain down the left leg. X stated that the pain was better with X. On examination, blood pressure was 139/73 mmHg. There were no significant changes in the physical exam since the prior office visit. The plan was to appeal for denial of X. An MRI of the lumbar spine dated X revealed at X. At X level, there was X. At X level, there was X. At X level, the X. X was noted causing X. The follow-up evaluation report dated X indicated that an X on X revealed X. X were identified on X. X was supportive of X. The X responses were of unclear X. Early and mild X could give rise to similar findings, and as such, individuals were often misdiagnosed with X. X was advised. Treatment to date X. Per a utilization review adverse determination letter and peer review report dated X by X, MD, the request for X was denied. Rationale: “Per ODG Low Back guidelines regarding criteria for X, “X must be well documented, along with X. X must be corroborated by imaging studies and when appropriate, X. A request for the procedure in a patient with X requires additional documentation of recent symptom worsening associated with deterioration of neurologic state.” In this case, there is no documented evidence of X. Therefore, the request for X is not shown to be medically necessary and non-certified. “On X, Dr. X placed an appeal for denial request of X. Per a reconsideration / utilization review adverse determination letter and peer review report dated X by X, MD, the request for X was denied. Rationale: “Regarding X, ODG states that X for a low back condition is conditionally recommended as a short-term treatment for X. Indications include X. There should be X. A request for the procedure in a patient with X requires additional documentation of recent symptom worsening associated with deterioration of the neurologic state. X is not a stand-alone procedure. There should be evidence of X. This can include a X. In this case, there is no documentation of recent symptom worsening associated with X. The recent note indicates that there are no significant changes in the physical exam. There is no specific X at the requested X. There is no plan

for X. Imaging reveals only X. Given the above, the request for X is not medically necessary. Recommendation is to deny. Patient with continued radicular pain symptoms with low back pain radiating down left lower extremity consistent with X. Subjective complaints and exam findings also correlate with MRI findings. Patient has attempted X. While timeframe since injury is over X months, and unclear if having acute flare of pain, patient's pain still significant X have not yet been attempted. Requested lumbar X is medically necessary and certified

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

Patient with continued radicular pain symptoms with low back pain radiating down left lower extremity consistent with X. Subjective complaints and exam findings also correlate with MRI findings. Patient has attempted X. While timeframe since injury is over X months, and unclear if having X. Requested X are warranted per ODG criteria. X is medically necessary and certified

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