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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 Overtuned (Agree in part/Disagree in part)

☒ Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured while working on X. X fell from X. The diagnoses were back pain (X) and stable burst fracture of first lumbar vertebra, initial encounter for closed fracture (X).On X, X was seen by X, PA / X, MD for follow-up office visit for X. X continued to complain of low back pain with radiation into X bilateral lower extremities (BLE), right more than left (RLE>LLE), that stopped at X knees. MRI of the lumbar-spine was reviewed. X was unable to stand more than X minutes due to BLE pain. X had completed X and was unable to tell if it helped it or if time passed. The ongoing pain was X and the worst pain was X. Dr. X reviewed imaging and X. X had an X due to finding a X with Dr. X. X had a history of X. X was a X. X took X, X was advised to X. X would like to proceed with X. On examination, blood pressure was 124/76 mmHg, weight 193.2 pounds and body mass index (BMI) was 25.49 kg/m2. X revealed X. Treatment plan included X. An MRI of the lumbar spine dated X revealed that at X, there was X noted. X was X. At the X, there was X. At the X, there was X. At the X, there was X. At the X, there was X. At the X, there was X. There was X. Treatment to date included X. Per a peer review dated X by X, MD, the request for X was denied. Rationale: “The surgical treatment plan is not supported by the treatment guidelines. The Official Disability Guidelines do not recommend X. According to the evidence-based guidelines, X is not recommended for X. X is no better than X. Recommended as an option for X . When considered, fracture age should not exceed X months. This patient has a history of an X. The patient has continued low back pain X. There is no indication for X. As a result, the medical necessity of the request is not established. Therefore, my recommendation is NON-CERTIFY the request for X. With noncertification of the concurrent request for X is not indicated. Therefore, my recommendation is to

NONCERTIFY the request for X." Per a peer review dated X by , MD, the appeal request for X was denied. Rationale: "No pertinent clinical information was submitted to supersede guidelines, and it remains relevant that the surgical treatment plan is not supported by the treatment guidelines. The Official Disability Guidelines do not recommend X. A peer review noncertified a request for X. Upon appeal, a cover sheet dated X notes that the patient presented with intractable back pain at the site fracture. X has X. However, this does not provide sufficient clinical evidence to supersede the treatment guidelines, especially considering this is a chronic injury and the X. For these reasons, I am unable to overturn the previous determination. Therefore, my recommendation is to NON-CERTIFY the request for X. Rationale: "With noncertification of the concurrent request for X, this associated request for X is not indicated. Therefore, my recommendation is to NONCERTIFY the request for X." Based on the submitted medical records, the requested procedure consisting of a X is not medically necessary. The guidelines do not support the request for X. No new information has been provided which would overturn the previous denials and/or whereby the guidelines would support. X are not medically necessary and non certified.

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

Based on the submitted medical records, the requested procedure consisting of a X is not medically necessary. The guidelines do not support the request for X. No new information has been provided which would overturn the previous denials and/or whereby the guidelines would support. X are not medically necessary and non certified.
Upheld

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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**