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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. The mechanism of injury was not available in the provided medical records. The diagnoses were strain of muscle, fascia, and tendon of lower back, subsequent encounter (X); other intervertebral disc displacement, lumbar region (M51.26); and sacroiliitis, not elsewhere classified (M46.1). On X, X was seen by X, NP / X, MD for a follow up visit for low back pain. X had work related injury on X. X did not have pain prior to this injury. At the time, X continued to complain of low back pain with radiating pain into X lower extremities. X also indicated numbing and tingling sensations that ran down X lower extremities as well. X had not yet been authorized. Pain was managed with the ongoing medication regimen. At the time, X rated pain as X, best was X, and worst was X. X had constant low back pain that was aching, sharp / stabbing, throbbing, and burning in nature. Aggravating factors included bending, sitting, standing, twisting, and walking, and massage alleviated the pain. On examination, blood pressure was 136/86 mmHg, weight was 303 pounds and BMI was 36.9 kg/m2. Physical examination revealed X. Lumbar spine examination revealed X. Lumbar range of motion (ROM) showed X. Facet tenderness and facet loading was X. There was decreased motor function in the right lower extremity seen as X at hip flexion, knee extension, dorsiflexion (DF), plantarflexion (PF), and extensor hallucis longus (EHL); and at X in left hip flexion, knee extension, DF, PF and EHL. Sensory examination revealed right diminished from X; and left diminished at X. Deep tendon reflexes were X+ throughout. Sacroiliac joint examination showed X. it was noted

that X tried to walk at home to exercise but continued to have severe muscle tightness causing limitations in X activities of daily living. A back brace was given. It was noted that X had tried and failed at least X. X had seen neurosurgery who had not recommended X. X had not been able to return to work since the injury since X was unable to lift heavy stuff. Treatment plan included X. An MRI of lumbar spine dated X revealed that at the X, there was X. The X were X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: "Per the Official Disability Guidelines by MCG (ODG) X site conditionally recommended as a short-term treatment for X. This treatment should be administered in conjunction with active rehabilitation efforts, including current X. X are not recommended as a treatment for X. X is not generally recommended. When required for extreme anxiety, a patient should remain alert enough to reasonably converse. The claimant had ongoing low back pain radiating to the lower extremities with numbness and tingling. There was X. There was a X and X. However, there was no documentation of the efficacy of X. As such, the medical necessity has not been established for X. "On X, Dr. X wrote an appeal/reconsideration letter in regards to X patient, X and the denial of a requested X. Dr. X documented, "My colleagues and I have been conservatively treating X in our office since X presented for an initial evaluation on X. Since this time, X has undergone X. X last presented in our office for a follow up examination on X complaining of lower back pain with radiation into X bilateral lower extremities as X described as tingling in nature with associated weakness in the lower extremities. X physical examination indicated on this day decreased X. There was X. There was decreased motor function in the right lower extremity X in hip flexion, knee extension, dorsiflexion, plantarflexion, and extensor hallucis longus. Strength in the left lower extremity was X in hip flexion, knee extension, dorsiflexion, plantarflexion, and extensor hallucis longus as well. Sensory deficits were X. Deep tendon reflexes were X throughout. X most recent

MRI of the lumbar spine was performed on X and indicated a persistent X. It is my professional medical opinion that X has met medically reasonable and necessary criteria for the approval of X. This criteria includes X subjective pain complaints, my clinical objective findings on physical examination, diagnostic studies that are consistent with reported pain complaints, and failure of all other forms of conservative treatment up to this point. Our goal is to provide X with the relief necessary for X to be able to perform X activities of daily living, sustain gainful employment, and improve X overall quality of life. Your consideration in the approval of this procedure is greatly appreciated. "Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: "Per Official Disability Guidelines by MCG (ODG) Low Back guidelines regarding criteria for X, "X may be indicated when ALL of the following are present X." In this case, the lumbar spine magnetic resonance imaging (MRI) did not reveal X. Moreover, ODG does not recommend X. The request is not shown to be medically necessary. Therefore, the requested X is non-authorized. "Thoroughly reviewed provided records including peer reviews. Based on provided documentation along with further explanation in appeal letter, patient does appear to meet the cited ODG criteria for X. Patient has X. There is some debate about X. However, no sufficient explanation provided to warrant use of X, thus only X is indicated. X is medically necessary and certified. 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. Based on provided documentation along with further explanation in appeal letter, patient does appear to meet the cited ODG criteria for X. Patient has X.

There is some debate about doing X. However, no sufficient explanation provided to warrant use of X is indicated. X is medically necessary and certified. 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