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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 biomechanics of the injury was not included in the provided records. The diagnosis included sprain of ligaments of lumbar spine; opioid dependence, uncomplicated; other specified sprain of right wrist; strain of flexor muscle, fascia and tendon of right middle finger at wrist and hand level and other sprain of right shoulder joint. On X, X was seen by X, MD for follow up of lower back with pain distally to the lower extremities. X complained of injury on the lumbar area. That was associated with pain. X described the pain as aching and dull, joint pain, joint swelling, morning stiffness, stiffness, strain and weakness. Pain was aggravated by walking, abnormal posturing, lifting heavy objects, range of motion and standing still. Pain was relieved by medications and rest. Examination of lumbar spine showed range of motion was restricted with flexion. Back movements were painful with flexion, extension, lateral rotation to the left and lateral rotation to the right. On examination of the paravertebral muscles, tenderness and tight muscle band was noted on both the sides. X was X. X was decreased and X were noted. X were recommended. X to the lumbar spine at X was recommended. On X, X presented to Dr. X for follow up and reevaluation of pain and discomfort to X lower back. X rated X pain X and discomfort to X lower back. X stated X had limited range of motion and X requested refills. X stated X pain increased when walking, standing and bending for long periods of time. X was working fulltime without restrictions. Examination of lumbar spine showed range of motion was restricted with flexion. Back movements were painful with flexion and extension. On examination of the paravertebral muscles, tenderness and tight muscle band was noted on both the sides. X was X. X had sacral dimples on the right. Tenderness was noted at both

sacroiliac joints. X was decreased and X were noted. X was administered in lumbar area. X were recommended. Unfortunately, the request for X was denied and Dr. X would like to appeal that decision. On X, X had a follow up with Dr. X for sprain of ligaments of lumbar spine; opioid dependence, uncomplicated; other specified sprain of right wrist; strain of flexor muscles, fascia and tendon of right middle finger at wrist and hand level and other sprain of right shoulder joint. As per X was working full duty. X rated X pain X and was taking X. As per X, X had X. X was also requesting X. Examination of lumbar spine showed range of motion was restricted with flexion. Back movements were painful with flexion and extension. On examination of the paravertebral muscles, tenderness and tight muscle band was noted on both the sides. X was X. X had sacral dimples on the right. Tenderness was noted at both sacroiliac joints. X was decreased and X were noted. X were recommended. Unfortunately, the request for X was denied. The reason was the fact that there was no documentation indicating that X was doing home exercise program. The case of injury was quite old and X had physical therapy several weeks during X active injury phase and had been doing home stretching for many years now with no improvement. The recent MRI was positive for protrusion at X and the recommendation was to do X. Approval for that was requested. An MRI of the lumbar spine dated X showed X. This was worse at X where there was severe X. X was noted. Contact of the exiting X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The injured worker received an unknown X. Furthermore, there are limited objective neurological findings to support medical necessity. Therefore, the request for X is non-certified. “Per a reconsideration review adverse determination letter dated X, by X, MD, the request for X was non-certified. Rationale: “In this case, there is no record of pain or focal neurological deficits specifically corresponding to X. Therefore, the appeal request for X is non-certified. “Thoroughly

reviewed provided records including peer reviews. Patient had X. However, as one reviewer points out, there are no deficits or dermatomal pattern of pain described in X. Further, given only just relatively recently had X is not warranted at this time. 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. Patient had X. However, as one reviewer points out, there are no deficits or dermatomal pattern of pain described in X. Further, given only just relatively recently had X is not warranted at this time. X is 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

☐ 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