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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.

X was seen by X, MD on X for low back pain. X reported X pain radiated into the left lower extremity. X was able to stand for more than X minutes; sit for less than X minutes; and walk for less than X minutes. X rated X pain X. The pain was described as constant stabbing and shooting pain down the left leg into X buttocks. The pain got better with lying down. X blood pressure was 159/92 mmHg. Lumbar examination revealed X. Motor strength in lower extremities was X bilaterally. X was X on the left. X experienced facet pain on spine rotation, extension, flexion, and palpation and axial loading. X had pain in the lumbar facets bilaterally at the X.

An MRI of the lumbar spine dated X revealed at X.

Treatment to date included X.

Per the Adverse Determination -- Utilization Review by X, MD on X, the request for X was non-certified. Rationale: “Per ODG Low Back guidelines regarding criteria for X, "Radiculopathy must be well documented, along with objective neurological findings on physical examination. Acute radiculopathy must be corroborated by imaging studies and when appropriate, electrodiagnostic testing, unless documented pain, reflex loss, and myotomal weakness abnormalities support a dermatomal radiculopathy diagnosis. A request for the procedure in a patient with chronic radiculopathy requires additional documentation of recent symptom worsening associated with deterioration of neurologic state." In this case, there is no documented evidence of neurological deficits

consistent with radiculopathy on physical examination. X are not shown to be medically necessary. Therefore, the request for X is non-certified."

Per the Appeal / Reconsideration Determination -- Utilization Review by X, MD on X, the request for X was non-certified. Rationale: "Regarding X, ODG states that X is conditionally recommended as a X. Candidates should be unresponsive to conservative treatment (e.g., exercise, physical therapy, nonsteroidal anti-inflammatory drugs, muscle relaxants, neuropathic drugs). In this case, the pain is not described in any specific radicular pattern correlated with X. There is limited evidence of findings on examination to support lumbar radiculopathy at the requested levels such as sensory deficits, myotome weakness, and reflex loss. There is no evidence of the claimant has X. Therefore, the medical necessity of this request is not established. The recommendation is to deny."

Thoroughly reviewed provided records including peer reviews.

Patient with symptoms of back pain radiating down left leg into gluteal area, along with physical exam findings including X. Patient attempted X. MRI revealed significant findings correlating with pain distribution. Requested procedure is indicated based on ODG criteria cited by peer reviews. X is medically necessary and 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 with symptoms of back pain radiating down left leg into gluteal area, along with physical exam findings including X. Patient attempted X.

MRI revealed significant findings correlating with pain distribution. Requested procedure is indicated based on ODG criteria cited by peer reviews. X is medically necessary and certified.

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)