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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 on X. The biomechanics of the injury was noted as X. The diagnosis was spinal stenosis of lumbar region with neurogenic claudication. There were no office visits available in the given records. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: "With regards to the X request, as stated in the guidelines. X is recommended, and that given frequency should be tapered and transition into a X. ODG guidelines allow for X. Guidelines indicate that for spinal stenosis: X is appropriate. Guidelines recommend that X should be tapered and transitioned into a X. The most commonly used active treatment modality is X, but other X may be recommended as well, including X. ODG states that it is generally not recommended as a first-line treatment modality for chronic pain, but although a X may be considered as a noninvasive 2nd-line option, only when subjective improvement and reduction in pain medication use have been previously documented during a program of evidence-based functional restoration. In this case, the clinical summary states that the date of injury (DOI) was in X and it is unclear how much X may have taken place in the past. There is no documentation of the Objective functional improvement through prior X. Also, it is unclear why additional X is being requested which exceeds guideline recommendations and unclear why patient cannot be X. Also, no recent exacerbations to clarify why additional X is necessary. Therefore, the request for X is hereby recommended not certified. "Per a reconsideration / utilization review adverse determination letter dated X, by X, MD, an appeal request for X was denied. Rationale: "This is an appeal request for X. The ODG recommends up to 10 visits of physical therapy for lumbar stenosis. The ODG does not support X. The documentation provided indicates the claimant has chronic low back pain with a diagnosis of lumbar stenosis. They have objective functional

impairments on physical examination. The provider has recommended X, but it is still unclear how much prior X has taken place, what objective functional improvement has been seen by the completed X, and why the claimant cannot proceed with a X. As such, the request for X is non-certified. “Thoroughly reviewed provided records which included two utilization reviews. There were no office notes supplied. Based on the supplied documentation, it appears that decision to not certify X request is appropriate. While the patient could potentially benefit from further X, it is unclear how much X the patient has had, if there was any improvement from prior X, or if there were any extenuating circumstances why a transition from formal X cannot be pursued. 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 which included two utilization reviews. There were no office notes supplied. Based on the supplied documentation, it appears that decision to not certify X request is appropriate. While the patient could potentially benefit from further X, it is unclear how much X the patient has had, if there was any improvement from prior X, or if there were any extenuating circumstances why a transition from X cannot be pursued 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**
- ☒ **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)**