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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 at work on X. X hurt the back while pulling a X. The diagnosis was sprain of ligaments of lumbar spine, initial encounter (X).

On X, X was seen by X, MD, for follow-up visit for chief complaint of low back pain. The pain radiated into the right lower extremity. An MRI of the lumbar spine was positive for X. X stated that X was able to stand for more than X minutes, able to sit for more than X minutes and able to walk for more than X minutes. At the time, pain level was X, pain level at the worst was X and pain level at best was X. The pain felt like constant soreness. The pain was better by walking. X reported improvement in overall pain by greater than X after the procedure of X. X was able to stand, sit and walk longer; had decreased pain medicine and had less stress. X was having pain again and would like another X. X was working full duty at the time. On examination, blood pressure was 132/87 mmHg. X was awake, oriented times three, and was in no acute distress. The lumbar examination showed X. The motor strength of lower extremities was X. The straight leg raise (SLR) was X. No pain was noted in the lumbar facets, bilaterally. The treatment plan was to proceed with X. On X, X was seen by Dr. X for a follow-up visit for chief complaint of low back pain. At the time, pain level was X, pain level at the worst was X and pain level at best was X. X reported no significant changes since the prior visit. X was denied. On examination, blood pressure was 144/98 mmHg. Physical examination was unchanged. They would appeal for denial of 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: “Regarding X, ODG notes that X is recommended as a first-line or second-line option. X may be indicated when there is radicular pain, duration of greater than or equal to X weeks, and X or more of the following including X. There must be X.

There is no documentation of objective gains or functional improvement after the X, which is required by the guidelines prior to consideration of a repeat procedure. There is also X. There are also X. Given the lack of support that the evidence-based guideline criteria have been met, the request for X is not medically necessary. Recommendation is to deny the request."

Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Per ODG Low Back guidelines regarding criteria for X: X. Procedure performed X. Therefore, the request for Appeal X is non-certified.

Based on the clinical information provided, the request for X is recommended as medically necessary. The submitted clinical records indicate that the patient underwent prior X. The patient reported greater than X improvement in overall pain after the procedure. The patient was able to stand longer, sit longer, and walk longer. The patient was able to decrease pain medication and had less stress. The patient is now having pain again and would like X. Given the patient's response to the prior X, the request is certified. X is medically necessary and certified.

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

Based on the clinical information provided, the request for X is recommended as medically necessary. The submitted clinical records indicate that the patient underwent X. The patient reported greater than X improvement in overall pain after the procedure. The patient was able to stand longer, sit longer, and walk longer. The patient was able to decrease pain medication and had less stress. The patient is now having pain again and would like X. Given the patient's response to the

X, the request is certified. 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)**