

P-IRO Inc

Notice of Independent Review Decision

Case Number: X

Date of Notice: X

P-IRO Inc.

An Independent Review Organization

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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

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PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X fell at least X. The diagnosis was status post left L4-L5 microdiscectomy with residual lumbar radiculopathy and foraminal stenosis.

On X, X was seen by X, MD, for a follow-up visit for low back pain and left leg pain. X was approximately X months' status post X. X repeat MRI had shown X. At prior visit, X had received an X. This X held for approximately X. At the time, X reported continued constant pain and numbness in X left leg. Examination revealed that X was X. Musculoskeletal examination revealed X continued to have a X. X had X. No other new findings on X examination was noted, and X otherwise had X. On assessment, X imaging and clinical condition was reviewed. X MRI imaging was reviewed which showed X continued to be X. At the time, Dr. X had tried performing a X. Given the location of X, Dr. X thought that the best way to decompress this area would be a X; however, this would destabilize the spine and therefore, X would benefit from a left X.

An MRI of the lumbar spine dated X revealed X. There was a left X. There were X. There was X.

An electromyography (EMG) report dated X revealed 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: "There is no evidence of X. ODG notes X. The patient is a X. There is a history of X. The patient is X. There is some continued low back and left lower extremity symptoms. The recent X MRI noted X. There are X. While findings are noted, there is no evidence of X. The requested X is not supported. Therefore, my recommendation is to non-certify the request for X. The X request is denied. The additional X requests are not supported. Therefore, my recommendation is to non-certify the request for X."

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On X, Dr. X requested for X.

Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: "X has not been confirmed by diagnostics. ODG notes X. A prior request for X was denied on X. Since the time of the last review, there are no additional clinical findings. The prior rationale remains relevant. This is a X. The recent report noted low back and radiating left leg pain. The recent X MRI noted a history of X. There are X. There is X. There are no findings to overturn the prior determination. Therefore, my recommendation is to non-certify the appeal for X. The X procedure is again non-certified. X is not indicated. Therefore, my recommendation is to non-certify the appeal for X."

Based on the submitted documentation, the requested X is not medically necessary. The imaging reports do not demonstrate the presence of X. No new information has been provided which would overturn the previous denials. Thus, the requested X remains noncertified. 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:

Based on the submitted documentation, the requested X is not medically necessary. The imaging reports do not demonstrate the presence of X. No new information has been provided which would overturn the previous denials. Thus, the requested X remains noncertified. X is not medically necessary and non certified

Upheld

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE