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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was X. The diagnoses were lumbar radiculopathy, lumbar neuroforaminal stenosis, cervical radiculopathy, cervical degenerative anterolisthesis C3-C4, cervical neuroforaminal stenosis, and cervical spondylosis. On X, X was seen by X, DO for a follow-up evaluation of neck and back pain. X had radiating pain down bilateral lower extremity posterior thigh, calf into the bilateral feet. Intermittently, X would have pain down right leg into the right big toe. X also had cervical related pain, centralized cervical spine, referred down right and left arm, right and left biceps into the right and left hand all X digits. Case was reviewed by orthopedic spine surgeon, Dr. X. MRl of the lumbar spine was reviewed. On examination, weight was 182 pounds and blood pressure was 141/96 mmHg. Pain score was X sitting, X standing, and X with activity. X was noted. Lungs showed X. The examination of the lumbar and cervical spine showed tenderness over the right and left X, increased on lumbar extension, tender at right and left X. There was X. There was X. Motor testing in upper and lower extremities showed strength X. There was no X. Straight leg raise was X. There was X. There was X. Treatment plan included to proceed with X. On X, X was seen by Dr. X for follow-up evaluation for chief complaint of neck and back pain. On examination, X weight was 182 pounds and blood pressure was 141/96 mmHg. Pain score was X sitting, X standing, and X with activity. X was noted. Lungs showed X. Examination of the lumbar and cervical spine showed tenderness over the right and left X. There was X. There was X. Motor testing showed X. There was X. Straight leg raise was X. There was X. On assessment, Dr. X stated that X had a clinical peer reviewer, X, MD, American Board of Preventative Medicine, was incorrect in X assessment as X stated clinical symptoms were nonspecific. X did have radiating pain in both legs in X. This was also correlated with the lumbar imaging of X. There was X in addition to facet arthropathy, X. X also stated there were no objective findings. X did have a X. Last review by orthopedic spine surgeon, Dr. X on X. As Dr. X stated there was no X. X continued with X. This would be an interlaminar approach X. All X. X was reviewed by orthopedic spine surgeon, Dr. X. At the time, X was on X. They were trying to utilize X. An MRI of lumbar spine on X showed that at X. At X. At X. At X. At X. At X. The cervical MRI dated X revealed that at X. At X. At X. At X. At X. At X. At X. At X.

Treatment to date included X. Per the utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per Dr. X, X had not seen the claimant for X. X has not been performed. We discussed the clinical findings. The claimant’s symptoms and findings are non-specific. There are X. There is X. Recommend non-certification. “Per the adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Regarding X. The procedure should be performed X. There must be failure to respond to X. In this case, the imaging reported does X. There is X. Moreover, there is X. Therefore, X is not medically necessary. “The requested X is not medically necessary. The submitted medical records including the imaging report X. In addition, there is X. No new information has been provided which would overturn the previous denials. 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:

The requested X is not medically necessary. The submitted medical records including the imaging report X. In addition, there is X. No new information has been provided which would overturn the previous denials. 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**

☒ **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)**