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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: X; 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. The mechanism of injury was described as X. The diagnosis was radiculopathy of lumbar region, low back pain, spinal stenosis of the lumbar region with neurogenic claudication, and intervertebral disc disorder with radiculopathy of lumbar region.

Per an undated letter, X, MD requested authorization for X.

On X, X, NP evaluated X for transition of care regarding back pain. X presented into clinic with complaints of lower back pain and right sided radicular complaints, X reported that X had been dealing with this for X week after hurting X back at X. X described pain as aching, throbbing, and sharp in nature. X reported that pain gets to be an X. X reported that X had tried X. X had a history of low back pain and had been through X. X admitted to radicular complaints to right lower extremity (RLE), reported that X was unable to feel X right foot. X reported that X did feel like X was getting weaker to X right side and was having issues walking upstairs due to this. X reported that radicular complaints were getting worse as each day passes. X admitted to frank weakness, Lumbar spine examination revealed X. There was X. Motor strength was X in right ankle dorsiflexion tibialis anterior and great toe extension extensor hallucis longus. Sensation was X. The images were reviewed with Dr. X and a X.

Per an independent medical examination dated X X, MD opined that Treatment for X X. This means that treatment should consist of an X. X to surgically remove the X.

An MRI of lumbar spine 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: “ODG notes that X. In this case, the records

note that the claimant sustained a X. The records do not support that the claimant X. There is no evidence that since date of injury, the claimant has X. As all clinical indications for X are not met, the medical necessity of X is not established. As X is deemed not medically necessary, the medical necessity of X is likewise not established. Recommendation is to deny."

Per a reconsideration / utilization review adverse determination letter dated X, by X, MD, the request for X is denied. Rationale: "This is an appeal of a previous denial for a X and is recommended not medically necessary. A prior denial rationale was not included for review. The records did not document X.X for the claimant were included for review detailing response and lack of progress with treatment No recent X were noted. No X were included for review detailing X to support the surgical request. It is noted that a X of the claimant was not included for review. ODG does not X. Given these issues which do not meet guideline recommendations, I do not recommend certification for this request."

The requested X is not medically necessary, as the submitted medical records do not demonstrate X. No additional records have been submitted to overturn the previous denials. The requested X is not medically necessary, as the submitted medical records do not demonstrate X. No additional records have been submitted to 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, as the submitted medical records do X. No additional records have been submitted to overturn the previous denials. The requested X is not medically necessary, as the submitted medical records do X. No additional records have been submitted to overturn the previous denials. X is not medically necessary and non-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)**