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***Notice of Independent Review Decision  
Amendment***

**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 Overturned (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 is a X who was injured on X. X slipped and fell onto the buttocks. The diagnosis was radiculopathy of lumbar region (X). On X, X, MD evaluated X to discuss surgery. X came to the clinical after worsening symptoms doing physical therapy. X stated that while doing X physical therapy session last week X experienced excruciating back pain with radiation down the right leg and over the course of the past day or 2, X had started to notice numbness of the right leg. X was ambulating with a cane secondary to the decreasing function of the right leg. On examination, X was obese. X was ambulating with a cane. The thoracic and lumbar spine range of motion was decreased. Sensation was decreased to pinprick and light touch in the right lower extremity X. X gait was wide based and antalgic. The plan was to proceed with X. An MRI of lumbar spine dated X revealed X. There was X. There was X. Treatment to date included X. Per a peer review and utilization review adverse determination letter dated X by X, MD, the X was denied. Rationale: "Per the updated ODG recommendations regarding X. In this case, X. X were documented. Further, the claimant's X. ODG does not recommend X. Given these above noted issues, certification for the X requests is not recommended. Therefore, the X is not medically necessary. "An appeal letter dated X was included in the records for X. Per a peer review and reconsideration / utilization review adverse determination letter dated X, by X, MD, the appeal request for X was denied. Rationale: "Based on the provided documentation, a Magnetic resonance imaging (MRI) of the lumbar spine on X showed the X. Unchanged X left subarticular disc extrusion, facet arthrosis, and ligament flavum hypertrophy. Unchanged X. Mild degenerative disease at other disc levels is unchanged. However, a physical examination of the

lumbar spine revealed no findings. The exam on X revealed an unremarkable exam. Per Official Disability guidelines, the recommended option may be a first-line or second-line option. The patient has low back pain. However, there are limited objective findings of the lumbar spine. There will need to be objective findings such as weakness, restricted range of motion, and positive provocation testing prior to surgical intervention. The request is not medically necessary. Therefore, the request for X is upheld and non-certified. “Based on the submitted medical records, the requested X is not medically necessary. The submitted records do not provide objective findings which would warrant the X request. The records do not reflect a progressive neurological deficit. The records do not indicate the presence of instability at 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:**

Based on the submitted medical records, the requested X is not medically necessary. The submitted records do not provide objective findings which would warrant the X request. The records do not reflect a progressive neurological deficit. The records do not indicate the presence of instability at 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)**