MET HEALTHCARE SOLUTIONS
2211 West 34th St. ● Houston, TX 77018
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

X:

IRO Case number: X

Description of the services in dispute

X

Description of the qualifications for each physician or 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:

- ☐ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☒ Partially Overturned (Agree in part/Disagree in part)

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

The claimant is a X diagnosed with chronic back pain syndrome with lumbar disc protrusions X with right lumbar radiculitis following work injury and secondary myofascial pain syndrome with generalized deconditioning associated with chronic back pain syndrome with lumbar disc protrusions X with right lumbar radiculitis following work injury. This review is to determine the medical necessity of a prospective request for X.

In the Initial Pain Evaluation by Complex Pain dated X, it is stated that the claimant was working for X. On X, X had X. The claimant's back pain persisted despite X. X was given an MR on X which X. The pain worsens with coughing, sneezing squatting, and lifting. X pain ranges from X to X daily. Neuromuscular examination revealed, "X. X had marked X. Decreased pinprick in the X. X did have tenderness at X. Toes were downgoing. No sudomtor or vasomotor changes were noted. Trigger points in the lumbar spine with jump signs were also elicited."

Follow-Up Note by Complex Pain dated X stated that the claimant was continuing to experience severe axial pain in X back, buttock, and leg following X work-related injury. X pain radiates to below the level of the knee. Physical examination resulted in a X. The document stated that, "X MRI has been corroborated to include lumbar disk disruptions at X."

Finally, the Denial Letter by X dated X stated that, "As a result of your request for a reconsideration of a previous non-certification, a physician reviewer who was not involved in the original determination has reviewed the request. All available records submitted with the original request, as well as any additional information submitted with this request for appeal, were taken into account. This correspondence serves as notification that the requested medical treatment listed below does not meet established criteria for medical necessity, based on our second physician's reconsideration review of the information submitted. The original determination is therefore upheld. The following details provide specific information about the determination: Specific Treatment Plan Requested X."

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

The claimant is a X diagnosed with chronic back pain syndrome with lumbar disc protrusions X with right lumbar radiculitis following work injury and secondary myofascial pain syndrome with generalized deconditioning associated with chronic back pain syndrome with lumbar disc protrusions X with right lumbar

radiculitis following work injury. This review is to determine the medical necessity of a prospective request for X.

The reviewer has covered the medical records, guidelines, and medical literature when coming to the determination for this claimant. In particular, the reviewer based X decision on X.

The claimant has imaging findings that are consistent with the radicular symptoms that X is experiencing. The claimant has attempted an adequate trial of nonsurgical management and the X. This is the most appropriate next step for the claimant's condition and should be approved based upon the standard of care.

The guidelines are met for the need for X. Therefore, the X is approved based upon ODG. The X that was used is not medically necessary or approved based upon ODG as this is a contraindication based upon these guidelines.

Therefore, the X is partially approved. The X is approved, but there is a lack of medical necessity for X.

Description and source of the screening criteria or other clinical basis used to make the decision

☐ ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase

☐ AHRQ - Agency for Healthcare Research and 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)

☒ ODG - Official Disability Guidelines & Treatment Guidelines