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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 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 who sustained an injury on X. X reported hurting back at work leading to surgery. The diagnoses included unspecified lower back pain and lumbar radiculopathy. Per the physical therapy progress note dated X by X, PT, X attended X since the evaluation. X reported X had noticed X was getting a lot better with stretching and strength, but continued to have an abnormal pain at X low back near X tailbone when X lifted X leg up, going up and down stairs, and with squatting. X endorsed difficulty with sleeping, difficulty with walking, difficulty with prolonged sitting, difficulty with prolonged standing, muscle spasm, numbness, and pain interfering with activities of daily living, stiffness, and weakness. X was restricted from lifting and carrying more than five pounds and bending and twisting. X Oswestry low back disability index score was X indicating moderate impairment. On examination, lumbar spine active range of motion revealed flexion X degrees, extension X degrees, right rotation X degrees, left rotation X degrees, right side bending X degrees, and left side bending X degrees. X X was X. X had limited trunk mobility, guarded stance, decreased hip extension that worsened with fatigue. Strength in hip and knee was X to X. Flexibility in right hamstring was moderate, hip flexors and lumbar paraspinals were moderately restricted. Flexibility in left hamstring was minimal, hip flexors were minimally restricted, and lumbar paraspinals was moderately restricted There was tenderness over X. X single leg stance was X seconds. X attended X with X, PT on X for low back pain and lumbar radiculopathy. X continued to report abnormal pain at X low back near tailbone. X stated the pain would come and go but there were days X could not tolerate the pain. X had improved strength with X. It was opined that X would benefit from X in order to improve muscular strength, motor control, and decrease pain to allow tolerance with activities and functional tasks for work. Treatment to date included X on

X, X, and X. Per the utilization review by X, MD on X, the request for continuation of X was non-certified. Rationale: The request is for X. The ODG guidelines recommended X visits over X weeks for Lumbago; Backache, unspecified. In this case, the individual had low· back pain with positive objective findings. However, the individual has already attended over X, which well exceeds the recommended number of visits per guidelines. The continued complaints after these many visits are not a good predictor that more of the same treatment has the potential to provide any further benefit. Further, the individual needs to be transitioned to X. Given these facts, the request for X is Not Medically Necessary or Appropriate. “Per the adverse determination by X, DO on X, the request for X was non-certified. Rationale: “The guideline conditionally recommends there is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with pain. Guidelines recommend allowing for a X. The guidelines recommend X. The individual has had the recommended number of visits X. Review of the physical therapy progress report of X questions the efficacy. There is decreased X. The provider’s progress report of X mentions a X. The recent MRI scan apparently is concerning for X. An X has been ordered but it is not clear if that has been approved. It is not a part of the current request. The current request for X has been denied by level 1 reviewer. Although it was stated during discussion that the individual was starting to show improvement at the end of the course of physical therapy, the patient has already had X. Given the MRI findings and clinical presentation and the X, the request is not medically necessary or appropriate and is denied. “In a letter dated X, X, PT wrote, “This is Dr. X, Clinical Director and X. I am writing this letter today to indicate my professional opinion that X continue with X. The patient was making good progress, but still having difficulties strengthening the RIGHT side of body and low back. Current research indicates nerve involvement post-operatively is somewhat common, and while the recovery stats of this surgery are

good, they are not X. Our main concern is getting the patient fit and able to return as soon as possible, but if not done properly it could lead to the patient requiring extended time to recover, secondary surgeries, or poor work performance overall which would not benefit the patient or the company X works for. While the typical recovery time line for our patients condition is typically X weeks, if X is going to be performing physically demanding tasks then it is not uncommon to require a longer time to make sure the strength and mobility are up to par. Because of this, we are strongly requesting further authorization for X. “Thoroughly reviewed provided records including imaging results, provider documentation, and peer reviews. Patient has had X for X back pain issues including X on X. X has had what appears to be X. The cited guidelines recommend X. While X apple letter mentions specific functional issues for patient to work on, there is a competing argument from the peer reviewers that perhaps the patient’s X is no longer effective given time and number X. However, given patient still X. On the other hand, the amount of X requested is excessive and there are no extenuating factors to explain why patient needs substantially more X than recommended.. Thus, X is warranted. X is modified to X is medically necessary and certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Thoroughly reviewed provided records including imaging results, provider documentation, and peer reviews. Patient has had X on X. X has had what appears to be X. The cited guidelines recommend X. While X apple letter mentions specific functional issues for patient to work on, there is a competing argument from the peer reviewers that perhaps the patient’s X is no longer effective given time and number of X.

However, given patient still with functional deficits and further therapy may be warranted. On the other hand, the amount of X requested is excessive and there are no extenuating factors to explain why patient needs substantially X than recommended.. Thus, X is warranted. X is modified to X is medically necessary and certified.
Partially Overturned

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)**