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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X was driving when X had a blow out that made X lose control of the vehicle when X was trying to get to the side. This made the truck flip over X times. X was injured in X neck, left arm, shoulder, and groin where an incision was made. The diagnoses were low back pain and lumbar sprain. On X, X was seen by X, DO for follow-up of low back pain. X rated the pain X. The onset of pain was sudden, constant, and stabbing, aching, and other (stinging) in quality. This was located at the neck (cervical) and low back (lumbar). The X made the pain better. It was worse all the time. Bony palpation of the lumbosacral spine revealed supraspinous ligament pain, upper lumbar region. It was noted that X primary complaint was midline upper lumbar pain. X was pointing tender over the supraspinous ligament. X possibly had a sprain of the supraspinous ligament, and an X would help determine if this was a source of pain. X had done therapy at X, about X sessions. The treatment plan including X was recommended. On X, X was seen by X, DO for follow-up for shoulder and low back pain. X rated pain X. The onset of pain was sudden, constant, and stabbing, aching, and other (stinging) in quality. This was located at the neck (cervical). The X made the pain better. It was worse all the time. Bony palpation of the lumbosacral spine revealed supraspinous ligament with pain, upper lumbar region. It was noted that X had history of an X. X had multiple injuries. X went to X; no records available for anything at the time of consultation and no consultation note present. X was doing X. The treatment plan was unchanged; they would schedule a X with Dr. X. An MRI of the lumbar spine dated X revealed X. Treatment to date has

included X. Per a utilization review adverse determination letter dated X and a peer review dated X by X, MD, the request for X was denied. Rationale: “The request is not medically necessary. The peer stated that the request for A X. Therefore, the request for X is not medically necessary. “Per a reconsideration review adverse determination letter and a peer review dated X by X, MD, the appeal request for X was denied. Rationale: “Based on the provided documentation, the claimant presented with back pain. Physical examination revealed X. The claimant has been diagnosed with a lumbar sprain. “Per ODG guidelines, there are conflicting studies regarding effectiveness of X, also called X, for low back pain, therefore it is not recommended. “Per ODG guidelines, X is considered an adjunct, not a primary treatment. Ultrasound guidance for X is not recommended. X with any X is not recommended.” A prior denial by Dr. X, dated X, was denied on the basis the peer indicated the request for X. It is noted the claimant has continued pain. However, the guidelines do not recommend this form of treatment for the low back. Furthermore, there was no indication the claimant has X. Therefore, the Appeal request for X is upheld. “The requested X is not medically necessary. The use of X is not supported. The guidelines do not recommend this form of treatment. There is no documentation that the claimant X. 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 use of X is not supported. The guidelines do not recommend this form of treatment. There is no documentation that the claimant has X . 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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL