

**Notice of Independent
Review Decision**

IRO Reviewer Report

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)
- (Disagree)

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

X, date of birth X, is a X diagnosed with low back pain and radiculopathy, lumbosacral region and seeking coverage for X. X will require X.

On the date of injury, the claimant stepped in to X. The current diagnoses include low back pain, radiculopathy, lumbosacral region. Lumbar MRI dated X shows X. X recess X. X is noted at this level. There is also noted X. Office visit note dated X indicates that the claimant presents with pain in the lower back with radiation to the buttock and leg. The claimant reported difficulty with activities of daily living and prolonged sitting and standing. The pain was aggravated by coughing, sneezing, lifting, and bending as well as Valsalva maneuvers. The claimant had X. On the exam, there was decreased X. There was marked X. There was marked X. There was X. Follow up note dated X indicates that the claimant continues with moderate to severe axial back, right buttock and right leg pain. X has X. The claimant has a history of X. X is expressing X. X anxiety has increased to a level that it is having to be treated as well now.

A prior request was non-certified noting that, "In this case, while there is documentation for low back pain with radicular symptoms that has not improved with X to clarify the medical necessity for X. The guidelines do not recommend the use of X. As such, the request for X is nonauthorized." The denial was upheld on appeal noting that, "Per ODG, ""X is NOT recommended for any of the following...Use of X."

The patient was diagnosed with low back pain and radiculopathy of the lumbosacral region. In this case, X is planned with X. ODG guidelines do not recommend X. Anxiety is said to be "moderate." Moreover, it is unclear why X would be needed to administer the "X" that is planned. The request is not shown to be medically necessary. Therefore, the requested X is non-authorized."

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

Given the additional clinical data, there is sufficient information to support a change in determination for the request for X. X will require X.

The claimant is noted to present with radicular findings on physical examination corroborated by imaging. Follow up note dated X indicates that the claimant continues with moderate to severe axial back, right buttock and right leg pain. X has X straight leg raising on the right. The claimant has a history of X. X is expressing X. X anxiety has increased to a level that it is having to be treated as well now. Only X is being requested at this time which is medically necessary in this case and supported by the Official Disability Guidelines & Treatment Guidelines. Therefore, I recommend certification and the denial of this request to be overturned.

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

ODG - Official Disability Guidelines &

Treatment 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)
X.

- Other Evidence Based, Scientifically Valid, Outcome Focused Guidelines (Provide A Description)