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An Independent Review Organization
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Notice of Independent Review Decision

Amended Date: X

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

X

Description of the service or services in dispute:

X

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)

Information Provided to the IRO for Review:

X

Patient Clinical History (Summary)

The patient is a X whose date of injury is X. X was working as a X. X was placed in inpatient rehabilitation for 6 weeks. MRI lumbar spine dated X shows at X. Severe X. X and X present. Mild X is identified. Office visit note dated X indicates that the patient complained of back pain and leg weakness. The pain was rated at X on average and X on VAS at its worst. The pain radiates down the legs with left greater than right, with numbness and tingling to the feet. The examination noted pain with lumbar motion, X strength in bilateral hip flexion iliopsoas, bilateral ankle dorsiflexion tibialis anterior, bilateral great to extensor halluces longus and plantar flexion gastrocnemius, X strength in right knee extension quadriceps, and X strength in left knee extension quadriceps. The patient has had X. The diagnosis was intervertebral disc disorder with radiculopathy of lumbar region. The plan was for an X. Office visit note dated X indicates chief complaint is back pain. Current medications are X. Physical examination notes decreased range of motion with pain on motion of back. There is X on left greater than right. X has X strength in muscles below the knee.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The request for X is recommended as medically necessary, and the previous denials are overturned. The initial request was non-certified noting that, "Per Official Disability Guidelines, Pain, Online Version (X), X, "Recommended as an option; may be a first-line or second-line option. ODG X may be indicated when ALL of the following are present (1) (2) (3) (4) (5): Radicular pain, duration of >= X or more of the following (3) (6) . Lumber radiculopathy by history (eg, radiation of pain and numbness along the distribution of the affected spinal root), and ALL of the following: Diagnostic imaging (eg, CT scan, MRI) correlates with symptoms. Procedure performed via caudal, interlaminar, or transforaminal approach'' In this case, the patient complained of back pain and leg weakness. The pain was rated at X on a visual analog scale (VAS) on average and X on VAS at its worst. The pain radiates down the legs with left greater than right, with numbness and tingling to the feet. The examination noted pain with lumbar motion, X strength in bilateral hip flexion iliopsoas, bilateral ankle dorsiflexion tibialis

anterior, bilateral great to extensor halluces longus and plantar flexion gastrocnemius, X strength in right knee extension quadriceps, and X strength in left knee extension quadriceps. The patient has had X. However, the official MRI report of the lumbar spine with corroborative findings of radiculopathy was not provided for review. Therefore, this is not medically necessary. Thus, this is not certified.” The denial was upheld on appeal noting that, “ODG conditionally recommends X. In this case, the claimant’s symptoms are not documented in an identified radicular pattern. The provided evaluation report indicates that MRI showed X. Additionally, no new or compelling Information was provided to justify reversal of the recent non-certification determination. Therefore, based on lack of demonstrated medical necessity and lack of guideline support, the request for Appeal for X is recommended not certified.” Additional information has been provided to address the issues raised by the prior denials. The main reason for prior denials was lack of MRI. The MRI of the lumbar spine has been submitted for review and does correlate with the patient’s exam findings. X has completed an adequate course of conservative treatment. Given the additional clinical data, there is sufficient information to support a change in determination, and the request is certified.

A description and the source of the screening criteria or other clinical basis used to make the decision:

☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines

☐ DWC-Division of Workers Compensation Policies and Guidelines

☐ European Guidelines for Management of Chronic Low Back Pain

☐ Internal 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 and Treatment Guidelines

☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and 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)