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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

Date: x: 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 sustained an injury on X. X tripped over metal beam; fell backward and injured his right ankle; and landed on his buttocks and injured his lower back. The diagnoses included sprain of muscle, fascia, and tendon of lower back.

X was seen by X, MD on X for a follow-up of back pain. X stated X felt little bit worse. X continued to have dull, sharp, throbbing, pins and needles, numb, and tingling. X rated X pain X. X was unable to work. X pain was constant and radiated into the right lower extremity from the back. X was following the treatment plan, but it was not helping. X was not taking any medications at the time. X had tried multiple sessions of X. MRI showed X. On examination, X toe and heel walking was poor on the right. Flexion, extension, and rotation of the lumbosacral spine had decreased X to X. Motor strength was X on the right side and X on the left side. Straight leg raise was X. There was X. X were noted at X. X was ordered to X. On X, X reported X felt about the same or worse and rated X pain X. X was unable to work. X continued to have constant pain. X stated any kind of activity made the pain worse and nothing made it better. X was following the treatment plan, which was not helping. X had received multiple sessions of X. X was getting continued delay of X care which could be alleviated with X. On examination, toe and heel walking was poor on the right. Flexion, extension, and rotation of the lumbosacral spine had decreased X. Straight leg raise was X. Motor strength was X in both lower extremities. Sensation was X. X were noted at the X.

An MRI of the lumbar spine on X showed compared with X, there was increase in X.

Per the utilization review by X, DO on X, the request for lumbar X was non-certified. Rationale: “The injured worker has radicular findings on exam, but the MRI showed only a X. There is X.”

Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “In this case, the injured worker presents with complaints of pain in the lower back radiating down to the right lower extremity, Clinical assessment revealed X. Despite undergoing X. The provider recommended the request X due to the injured worker's anxiety; however, guidelines do not support the use of X. Therefore, this request cannot be certified at this time.”

Thoroughly reviewed provided records including provider notes, imaging findings, and peer reviews.

While patient has X. A X is noted at X. However, this pathology does not appear to be of significant severity to result in nerve involvement that would benefit from X. Further, X is not normally recommended for 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:
Thoroughly reviewed provided records including provider notes, imaging findings, and peer reviews.

While patient has X. A X is noted at X. However, this pathology does not appear to be of significant severity to result in nerve involvement that would benefit from X. Further, X is not normally recommended for 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:

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

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

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE