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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 Overtuned (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 was injured on X. X was at work and was X. The diagnoses were lumbar sprain (X), cervical sprain (X). On X, X underwent X. X reported positive impact to the following functions / activities: driving, family / home responsibilities, job performance, life support activities, personal / self-care, recreation, sitting, sleep pattern, walking and standing. At the time, X was on no pain medication. Leg symptoms continued to be improved X. Lumbar / hip discomfort continued, left more than right. Pain was increased on extension / rotation bilaterally, left more than right. No symptoms below the knee were reported. Oswestry back disability index total score was X, and the total disability percentage was X. On examination, X was in no acute distress. X pain behaviors were as expected within the context of X ongoing complaint. Physical examination was deferred due to tele visit. Treatment plan included proceeding with a X, was the preferred procedure to determine X. On X, X was seen by X, MD via telehealth follow-up visit for evaluation of low back pain. X had experienced a significant (at least X) improvement in symptoms. The pain severity showed the ongoing pain was X, moderate pain; high over the last week of X, severe pain; and low over the last week of X, moderate pain. X had participated in home exercises. An MRI of the lumbar spine dated X revealed X. There was a X. At the X. At the X. The spinal canal was upper limits of normal. The neural foramina showed X. The X. Pseudodisc of listhesis caused considerable compression of the X. The spinal canal was upper limits of normal. The neural foramina showed X. The X showed there was X. The spinal canal was X. The neural foramina showed X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Official Disability Guidelines recommend X)
. X, the claimant presented with low back complaints. They have experienced a significant (at least X) improvement in symptoms. They have participated X. They are X on X and reported positive impact to some daily functions and activities. They are currently not on pain medications. Leg symptoms continue to be improved X. Lumbar/hip discomfort continues, left more than right. Pain is increased on extension/rotation bilaterally, left more than right. They report back

pain and neck pain. They were examined remotely via telemedicine. Pain behaviors are as expected. Facet loading (Kemp's test/Extension Rotation - Ipsilateral Pain): positive bilaterally. Lumbar spine MRI showed X. In this case, there is no X. Furthermore, guidelines do not recommend X. As such, the request for X is non-certified. "On X, Dr. X wrote an appeal letter regarding denial of request of X: There was no evidence of X were not recommended X. Regarding this, Dr. X wrote, "See attached PT report. It is unclear whether the peer reviewer was provided the documentation we submitted with this request. The X follow up from the X indicated X relief and the X follow up specifically states resolution of leg symptoms. "Patient is currently on no pain medications. Leg symptoms continue to be improved post X. Continued improvement more than X r/e extremity symptoms. Recurrent low back/hip symptoms. "Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: The Official Disability Guidelines recommend X. In this case, there was a prior denial as there is no evidence of X. Furthermore, the guidelines do not recommend X. Additional documentation states that the claimant has had an X, with X improvement in X. However, there remains absence of X. Hence, the request is not medically necessary. Recommend noncertification of the requested X. Peer to peer was unsuccessful. "Thoroughly reviewed provided records including provider notes and peer reviews. Patient had X prior which has since improved after X. The patient remains with back pain symptoms that the provider attributes to facet-mediated pain. The patient has had X. Thus, proceeding to intervention X is warranted based on cited ODG criteria by peer reviews. 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 provider notes and peer reviews. Patient had X prior which has since improved after X. The patient remains with back pain symptoms that the provider attributes to facet-mediated pain. The patient has had X. Thus, proceeding to intervention requested X is warranted based on cited ODG criteria by peer reviews. X is medically necessary and certified.
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)**