Clear Resolutions Inc.
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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)

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Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured at work on X during X. X stated that after X. However, X right foot and lower back were also hurt. The diagnosis was sprain / strain of muscle, fascia, and tendon of lower back. On X, X was seen in follow-up by X, MD, for the chief complaint of low back pain. X was being re-evaluated with respect to a work-related injury sustained while working on X. X felt worse, sharp, numb, and tingling, X pain that was constant. At the time, X reported more frequent pain. X was following the treatment plan, but it was not helping. Previously, X had not wanted to do X, but at the time, X did want to go ahead. X had received multiple sessions of X. X had an MRI showing X. A review of systems was positive for low back pain radiating to the left lower extremity, and weakness, numbness, and tingling in the left lower extremity. X was working full duty. On examination, X was a well-developed, well-nourished X, appearing stated age and in no acute distress. Musculoskeletal examination showed X. Flexion, extension, rotation of lumbosacral spine was decreased X in all planes. Straight leg raise was positive on the left, negative on right. Paravertebral spasms were present X. Motor strength was X in both lower extremities. Decreased dermatomal sensation was noted in left X. The assessment was lumbar strain / sprain. Dr. X planned to do on a separate occasion, left X and then on a separate occasion at X followed by X. Dr. X noted that X had reached a point where the decision was to proceed with an X. This was based upon the complex nature of the injury, how it was impacting X bodily function, as well as the fact that they had exhausted all X. At this stage, X would require X intervention in order to retain / regain their bodily function and process toward pre-

injury functionality. On X, X was seen by Dr. X, for a follow-up of low back pain. X felt worse, numb, tingling, pins and needles, X pain. X was unable to work, although X was working light duty. X reported constant pain, made worse by nothing in particular, and did not get better. X had X without any improvement. X had not helped. X had been denied X that they had requested that was delaying X care. X had an MRI. On examination, X was a well-developed, well-nourished X, appearing stated age and in no acute distress. Musculoskeletal examination showed X. Flexion, extension, rotation of lumbosacral spine were decreased X in all planes. Straight leg raise was positive on the left, negative on right. Paravertebral spasms were present at X. Motor strength was X in both lower extremities. Dr. X noted they would appeal the denial of the X. X-rays of lumbar spine dated X revealed X. There was X seen at X. The X were X. No X were seen. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied as not appropriate and medically necessary for the diagnosis and clinical findings. Rationale for denial of X: “Official Disability Guidelines recommends X. On X, the claimant complains of low back pain rated X with numbness and tingling radiating to the left lower extremity. Exam shows X. Official MRI results for the lumbar spine were not included for review. As such, the request for X is non-certified.” Rationale for denial of X: “Official Disability Guidelines recommends X. On X, the claimant complains of low back pain rated X with numbness and tingling radiating to the left lower extremity. Exam shows X. Official MRI results for the lumbar spine were not included for review. As such, the request for X is non-certified. “Per a reconsideration review adverse determination letter dated X by X, MD, the appeal requests for X were denied as not appropriate and medically necessary for this diagnosis and clinical findings. Rationale for denial of X: “ODG by MCG (www.mcg.com/odg) states, "X may be indicated when ALL of the

following are present X. Procedure performed X." "X. Physical therapy, or documentation of patient intolerance to physical therapy." Within the documentation provided for review, the claimant has lower back pain with radicular symptoms. The claimant has exam findings of positive straight leg raise and altered sensation along the X. The claimant remains symptomatic despite X. The record indicates the claimant has disc herniation at the X, However, the referenced MRI has not been submitted for review to confirm diagnostic evidence of radiculopathy. The request for X is not medically necessary. Therefore, the request is denied." Rationale for denial of X: "ODG by MCG (www.mcg.com/odg) states, "X." "X, as indicated by ALL of the following X." Within the documentation provided for review, the claimant has lower back pain with radicular symptoms. The claimant has exam findings of X. The claimant remains X. The record indicates the claimant has X. However, the referenced MRI has not been submitted for review to confirm diagnostic evidence of radiculopathy. The request for X is not medically necessary. Therefore, the request is denied. "Thoroughly reviewed provided records including provider notes and peer reviews. Patient with continued pain in potentially radicular distribution despite pursuing conservative treatment options. Given corresponding imaging findings, a request for X is appropriate. There is a question about the official MRI report, but the provider's documentation of findings or their own interpretation is sufficient to meet cited ODG criteria when viewed in concert with other documentation submitted. X is medically necessary and certified

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

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Thoroughly reviewed provided records including provider notes and peer reviews. Patient with continued pain in potentially radicular distribution despite pursuing conservative treatment options. Given corresponding imaging findings, a request for X is appropriate. There is a question about the official MRI report, but the provider's documentation of findings or their own interpretation is sufficient to meet cited ODG criteria when viewed in concert with other documentation submitted. X is medically necessary and certified
Overturned

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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)**