

IRO Express Inc.
Notice of Independent Review Decision

IRO Express 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 Overturned Agree in part/Disagree in part
- Upheld Agree

IRO Express Inc.
Notice of Independent Review Decision

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. The mechanism of injury was not provided in given medical records. The diagnoses were lumbar radiculopathy (sciatica), other intervertebral disc displacement; lumbar region and post laminectomy syndrome, lumbar region.

On X, X was evaluated by X, DO for follow-up of low back pain. X presented for an evaluation of ongoing numbness and weakness in the left lower extremity. X had been having ongoing pain for several months. X denied any accident or injury. The left lateral shin felt asleep during the day. X did have some stiffness in X low back in the morning, but this improved with activity. X did not really have any pain in the leg. This had been ongoing since X for the last X months. X had numbness off and on. X had not noticed significant weakness in the leg. X had not done any therapy. X had pain in the lower back and left leg. It was frequent, dull / aching, like pins and needles, and had numbness and weakness. X rated pain on good day as X, on a bad day X, ongoing pain as X, with medication X and without medication X. Aggravating factors were activity and rest; alleviating factor was lying down. Physical examination revealed X. Lumbar spine examination revealed X. The range of motion showed X. Tenderness was noted in the X. X had pain

IRO Express Inc.

Notice of Independent Review Decision

with extension and rotation. The muscle strength in the left lower extremity was X in the extensor hallucis longus (EHL), X in dorsiflexion and plantarflexion, and X in quadriceps, hamstring and interphalangeal joints. Sensation was X. Straight leg raise test was X. Deep tendon reflexes were X at right patella and right and left Achilles, and X at left patella. X-rays of the lumbar spine was reviewed and showed severe X. MRI of the lumbar spine was ordered. X was prescribed. On X, X was evaluated by Dr. X, via telemedicine for review of MRI. MRI findings were explained to X. X was still having significant left leg symptoms. X still had weakness, sensory changes, pain, and numbness. On examination, X was alert and oriented. Skin showed old scar. Station was normal. Toe walking was within normal limits. X was unable to perform heel walking due to left weakness. Lumbar range of motion was unchanged as per previous observation. There was increased pain with extension, increased pain with right rotation and tenderness to palpation of the bilateral paraspinous region. Strength was X in left extensor hallucis longus, X in left dorsiflexion and left plantarflexion. Sensation was decreased in the left lower extremity and left lower shin. Deep tendon reflexes were X in right patellar and bilateral Achilles and X in left patellar. MRI of the lumbar spine was reviewed. X-rays of the lumbar spine showed X. The assessment was lumbar radiculopathy (sciatica) and other intervertebral disc displacement of lumbar region. X on the left were recommended. On X, X was evaluated by Dr. X for follow-up of low back pain. They were unable to get X, approved for X, as recommended. They had great difficulty getting a hold of the doctor, as X would never answer X phone when X was supposed to be available. X was still having significant numbness and weakness in the left lower extremity. X had got a feeling that X foot was asleep. X was not having significant pain at the time. At the time, X rated the pain as X, it could not range up to a X based on activity. X was taking X as needed, also X

IRO Express Inc.

Notice of Independent Review Decision

had been taking X, which X felt gave X some discomfort. X was having some difficulty in sleeping because of the discomfort in X leg as well. X complained of left leg pain with numbness. X rated pain on a good day as X, on a bad day as X, and at the time as X, with medication X and without medication X. On examination, weight was 225 pounds and body mass index (BMI) was 28.89 kg/m². Physical examination revealed X. Lumbar spine examination revealed X. Lumbar range of motion was per previous observation. Flexion was within normal limits. There was increased pain with extension, increased pain with right and left rotation, and tenderness to palpation in the paraspinous region bilaterally. X had pain with extension and rotation. Strength testing revealed X strength in left extensor hallucis longus, and X in left dorsiflexion and left plantarflexion. Sensation was decreased in the left lower extremity lateral shin. Straight leg raise was positive on the left. Deep tendon reflexes were X at right patellar, right and left Achilles, and X at left patellar. It was noted that X did have X. X had a laminectomy and discectomy on the left. X had X. They were trying to get an X approved.

An MRI of the lumbar spine dated X revealed X. Level by level findings showed that at the X. X was present. There was X was noted. X was present. At the X. There was X noted. At the X. There was X. X was present. At the X. X was present.

Treatment to date included medications X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "ODG by MCG Last review/update date: X, X Treatment type: X. Based on the information provided, the patient had lower back pain. Examination was done via

IRO Express Inc.

Notice of Independent Review Decision

telehealth, increased pain with extension and rotation, tenderness to palpation (TTP) bilateral paraspinous region, decreased sensation lower extremity, and decreased left lower shin. In this case, the documentation did not delineate the trial and failure of conservative care. Specific document stating the most recent time that conservative care was trialed as well as the length of time the conservative measures were trialed, the quality of the conservative measures should be established within the documentation before recommending X. Therefore, this request is not medically necessary. As such, the requested X is non-authorized.”

On X, X, Surgery Scheduler, wrote an appeal letter on behalf of Dr. X regarding denial of request for X level, stating, “This is being submitted requesting a request for a X. I am requesting a pre authorization appeal. I have attached a copy of the submitted documentation. Also, X has tried conservative care. Consisting of previous chiropractic visits and home exercises. Dr. X should be contacted at X. (IF POSSIBLE, PLEASE CALL ON MONDAY OR WEDNESDAY BETWEEN 9:30-1 :00) Please reconsider this request. We made several attempts to reach the peer Doctor. X wasn't available.”

Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “ODG by MCG do not address X. Alternate chapter cited: ODG by MCG Last review/update date: X, X: X. The requested X is not medically necessary or appropriate. There is no documentation provided to demonstrate that the patient has attempted X. As such, no new information has been provided that would overturn the previous denial. Therefore, the requested Lumbar X is non-authorized.”

IRO Express Inc.

Notice of Independent Review Decision

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "ODG by MCG Last review/update date: X, X: X. Based on the information provided, the patient had lower back pain. Examination was done via telehealth, increased pain with extension and rotation, tenderness to palpation (TTP) bilateral paraspinous region, decreased sensation lower extremity, and decreased left lower shin. In this case, the documentation did not delineate the trial and failure of conservative care. Specific document stating the most recent time that conservative care was trialed as well as the length of time the conservative measures were trialed, the quality of the conservative measures should be established within the documentation before recommending X. Therefore, this request is not medically necessary. As such, the requested X is non-authorized." Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "ODG by MCG do not address X for the low back. Alternate chapter cited: ODG by MCG Last review/update date: X, X: X. The requested X is not medically necessary or appropriate. There is no documentation provided to demonstrate that the patient has attempted an X. As such, no new information has been provided that would overturn the previous denial. Therefore, the requested X is non-authorized." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no documentation of a course of X. There are no X records submitted for review. Per note dated X, the patient was recommended to move forward with some X. It was noted that X would be seen back after X was completed. There are no subsequent records provided. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is not medically necessary and

IRO Express Inc.

Notice of Independent Review Decision

non-certified.

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

X

Upheld

IRO Express Inc.

Notice of Independent Review Decision

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