

C-IRO Inc.

Notice of Independent Review Decision

C-IRO Inc.

An Independent Review Organization

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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**

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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)

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 sustained an injury on X. At work, X felt back and left shoulder pain X. The diagnoses included strain of muscle, fascia, and tendon of lower back and left lumbar radiculitis.

X was seen by X, MD on X for a follow-up of lumbar spine pain. X reported that X felt about the same. X had sharp pain, pins and needles, X pain, constant pain. It was made worse by walking and sitting. X had no new symptoms. X was following the treatment plan, but it was not helping. X was working light duty. X had received X. X stated X. X did not have any X. Examination of the lumbosacral spine showed toe and heel walking good. Flexion, extension, and rotation of the lumbosacral spine decreased X to X in all planes. Motor strength was X in both lower extremities. Sensation was decreased in X. There were paravertebral spasm on the left side at X. Straight leg raise was X. It was noted that due to lack of improvement with conservative treatment, at this time in the treatment plan, the provider felt that X would benefit from X. The procedure was necessary to identify the pain generator(s) and to relieve

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pain so that X could participate in a higher level and more meaningful X with the hope of returning to the former employment or continue with the current employment either modified or regular work.

An MRI of the lumbar spine dated X showed X. At X, mild broad-based X. At X, mild broad-based central / left X was present resulting in X.

Treatment to date included medications X.

Per the Notice of Adverse Determination by X, MD on X, the request for X was non-certified. Rationale: "In this case, the individual has X. The most recent medical report included for review dated on X indicates X. Review of records indicates that the individual has previously attended X. However, there is no documentation to include the dates, number of sessions attended, or objective or functional outcome from X. Furthermore, it is documented that the individual is X. Based on the above findings, the medical necessity is not established."

The request for X is Not Medically Necessary or Appropriate. Rationale: "in this case, the individual has X. The most recent medical report included for review dated

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X indicates tenderness of the lumbar spine, muscle spasms, limited ROM, and positive SLR on the left. There are no objective findings of sensory or motor deficits. Review of records indicates that the individual has previously attended X. However, there is no documentation to include the dates, number of sessions attended, or objective or functional outcome from X. Furthermore, it is documented that the individual is not currently X. Of note, this request was non-certified on a previous utilization review dated on X. Based on the above findings, the medical necessity is not established.”

Per the Adverse Determination X, MD on X, the request for X was noncertified. Rationale: “Official disability guidelines conditionally recommend X. X are recommended when there is documentation of sustained improvement of pain or function of X, as measured from baseline, for X weeks after X with recurrent pain or deterioration in function since prior injection that causes functional disability. In this case, the individual has X. The most recent medical report included for review dated X indicates tenderness of the lumbar spine, muscle spasms, limited ROM, and positive SLR on the left. There are no objective findings of sensory or motor deficits. Review of records indicates that the

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individual has previously attended X. However, there is no documentation to include the dates, number of sessions attended, or objective or functional outcome from X. Furthermore, it is documented that the individual is not currently taking X. Of note, this request was non-certified on a previous utilization review dated on X. Based on the above findings, the medical necessity is not established. As such, the request is not medically necessary or appropriate and is denied.”

The request for X was Not Medically Necessary or Appropriate. Rationale: “Official disability guidelines conditionally recommend X, X are recommended when there is documentation of sustained improvement of pain or function of a X, as measured from baseline, for X weeks after X with recurrent pain or deterioration in function since prior X that causes functional disability. In this case, the individual has X. The most recent medical report included for review dated X Indicates tenderness of the lumbar spine, muscle spasms, limited ROM, and positive SLR on the left. There are no objective findings of sensory or motor deficits. Review of records indicates that the individual has previously attended X. However, there is no documentation to include the dates, number or sessions attended, or objective or functional outcome from X.

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Furthermore, it is documented that the individual is not currently X. Of note, this request was non-certified on a previous utilization review dated on X. Based on the above findings, the medical necessity is not established. As such, the request is not medically necessary or appropriate and is denied.”

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

Patient with symptoms of pain in potentially radicular distribution with corresponding MRI findings consistent with potential nerve root impingement. They have attempted X. Thus, request for X are warranted. X are medically necessary and certified

However, provider is also requesting X. It is unclear why they are requesting both procedures based on documentation provided and assessment is listed on all documentation as “lumbar sprain and strain.” Thus, additional request for X are not warranted. X is not medically necessary and non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION

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

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

Patient with symptoms of pain in potentially radicular distribution with corresponding MRI findings consistent with potential nerve root impingement. They have attempted X. Thus, request for X are warranted. X are medically necessary and certified

However, provider is also requesting X. It is unclear why they are requesting both procedures based on documentation provided and assessment is listed on all documentation as “lumbar sprain and strain.” Thus, additional request for X are not warranted. X is not medically necessary and non-certified.

Modified

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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**

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- 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)