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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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured at work on X, when X was X. The diagnosis was lumbar region radiculopathy (X).

X was evaluated by X, MD, on X, with respect to X alleged work-related injury on X. X had severe low back pain radiating in the left lower extremity. X was able to do X of X job. X felt numbness and tingling. There was an X. It felt as if it was sharp pressure, did not exist prior to the injury. It was intermittent pain made worse by standing too long; lying down on the floor made it better. X had X. X had not helped. X was not working at the time. X was seen orthopedics. X was on X. Regarding activities of daily living, X was able to do everything except for climbing up a flight of stairs, taking a bath, working outdoors on flat ground, and running errands. Musculoskeletal examination revealed X was poor on the left. Flexion, extension, and rotation of the lumbosacral spine was X. Motor strength was X in both lower extremities. Sensory was decreased on the left at the X. X was positive on the left, negative on the right. Paravertebral spasm was noted at X. The assessment was lumbar sprain / strain (X). Left X would be of benefit to X. X was extremely anxious and would require some X. X would be seen back in X weeks if this was denied. Regarding X, Dr. X noted, “The patient has reached a point in the treatment plan where the determination is to now proceed with a X. This decision is based upon the complex nature of the injury, how it is impacting the patient's bodily function, as well as the fact that we have exhausted all X. The patient will require this X in order to retain / regain their bodily function and process toward pre-injury functionality. The patient has elected to proceed with the X.” On X, X visited Dr. X for a follow-up. X had the same throbbing, X pain, and was able to do about X of X job. X had occasional pain, intermittently worse by bending and standing too long; stretching made it better. X reported no new symptoms and

was following the treatment plan, but it did not help. X had not been X. X had X. X had not helped. X had been denied X in spite of meeting ODGs. X had an MRI. Musculoskeletal examination revealed flexion, extension, and rotation of the lumbosacral spine was X. X was noted at X. Dr. X would appeal the denial of the X.

An MRI of the lumbar spine dated X, revealed X. There was some X. The visualized cord demonstrated X. There was no evidence of X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Regarding X, the Official Disability Guidelines recommend an X. and performed X. They should have failed to respond to X. Other factors, including functional disability due to pain, limited X. The use of X. Per the submitted documentation, the request is not warranted. According to the guidelines, X. Other factors, including functional disability due to pain, limited X. In this case, the request may be indicated considering the injured worker's chronic severe low back pain radiating in the left lower extremity with numbness and tingling, diminished sensations along the left X. These findings were suggestive of radiculopathy, and spinal imaging showed X. However, the approach and the kind of X to be used were not specified. A phone call to the office of X, M.D., on X was attempted to discuss the requested care: specifically, the specific approach of the requested X. The provider was unavailable; therefore, a message was left for X informing that the office was already closed and advising to call the office between 8:00 AM to 5:00 PM. Hence, the request cannot be authorized at this time. Therefore, the X is non-certified."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "The prior non-certification under review number X was based on the X. The provider submitted a referral prescription dated X indicating a request for a X. Based on the medical record, the injured worker sustained an injury X. The diagnoses were radiculopathy of the

lumbar region and lumbar sprain/strain. The injured workers work status was undisclosed. Attempted treatments included X. An undated lumbar spine X-ray showed no X. However, an MRI of the lumbar spine dated X revealed a X. Notably, an X. The left X. Mild narrowing of the X was also noted. According to the initial report submitted by X, MD, dated X, the injured worker presented severe low back pain radiating into the left lower extremity, accompanied by numbness and tingling. The pain was described as sharp, intermittent, and pressure-like and worsened with prolonged standing. Objective findings included X. The provider recommended a left X. A subsequent progress report submitted by X, MD, dated X, noted that the injured worker continued to report throbbing pain rated at X and was able to perform approximately X of job duties. Pain was intermittent and worsened by bending or prolonged standing but stretching provided relief. No new symptoms were reported. The injured worker also experienced low back pain radiating into the right lower extremity. Physical examination revealed a X. The X. The provider is appealing the prior determination at this time. Regarding X, the Official Disability Guidelines recommend an X. and performed X. They should have X. Other factors, including functional disability due to pain, X. The use of X is not recommended. Per submitted documentation, the request is not warranted. The referenced guidelines recommend X. The guidelines recommend the use of X. The use of X is not recommended. Based on the injured worker's clinical findings of a X. However, a recent progress report dated X documented significant functional improvement, with pain reduced to X, the ability to perform X of job duties, and no new or worsening symptoms. Furthermore, the requested X. Since the injured worker demonstrated X not supported by current guidelines, the request is not medically necessary at this time to treat the lumbar condition. Therefore, the prospective request for X is non-certified."

(Based on the clinical information provided, the request for Left X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Regarding X. and performed X. They should have X.

Other factors, including functional disability due to pain, X. The use of X is not recommended with X. Per the submitted documentation, the request is not warranted. According to the guidelines, these X. Other factors, including functional disability due to pain, limited X. In this case, the request may be indicated considering the injured worker's chronic severe low back pain radiating in the left lower extremity with numbness and tingling, X. These findings were suggestive of radiculopathy, and spinal imaging showed X. Hence, in accordance with established protocols. However, the approach and the kind of X to be used were not specified. A phone call to the office of X, M.D., on X was attempted to discuss the requested care: specifically, the specific approach of the requested X. The provider was unavailable; therefore, a message was left for X informing that the office was already closed and advising to call the office between 8:00 AM to 5:00 PM. Hence, the request cannot be authorized at this time. Therefore, the prospective request for X is non-certified."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "The prior non-certification under review number X was based on the X. The provider submitted a referral prescription dated X indicating a request for a X. Based on the medical record, the injured worker sustained an injury while X. The diagnoses were radiculopathy of the lumbar region and lumbar sprain/strain. The injured workers work status was undisclosed. Attempted treatments included X. An undated lumbar spine X-ray showed X. However, an MRI of the lumbar spine dated X revealed a X. Notably, an X. The left X. Mild narrowing of the X was also noted. According to the initial report submitted by X, MD, dated X, the injured worker presented severe low back pain radiating into the left lower extremity, accompanied by numbness and tingling. The pain was described as sharp, intermittent, and pressure-like and worsened with prolonged standing. Objective findings included X. The provider recommended a X. A subsequent progress report submitted by X, MD, dated X, noted that the injured worker continued to report throbbing pain rated at X and was able to perform approximately X of job duties. Pain was intermittent and worsened by bending or prolonged standing but stretching provided relief. No

new symptoms were reported. The injured worker also experienced low back pain radiating into the right lower extremity. Physical examination revealed a X. The X. The provider is appealing the prior determination at this time. Regarding X, the Official Disability Guidelines recommend an X. and performed X. They should have X. Other factors, including functional disability due to pain, limited X. The use of X is not recommended. Per submitted documentation, the request is not warranted. The referenced guidelines recommend X. The guidelines recommend the use of X. The use of X is not recommended. Based on the injured worker's clinical findings of a X. However, a recent progress report dated X documented significant functional improvement, with pain reduced to X, the ability to perform X of job duties, and no new or worsening symptoms. Furthermore, the requested X. Since the injured worker demonstrated clinical improvement and the request included X not supported by current guidelines, the request is not medically necessary at this time to treat the lumbar condition. Therefore, the prospective request for X is non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The most recent office visit note submitted for review X. This note indicates that on X. Guidelines note that 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:

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "The prior non-certification under review number X. The provider submitted a referral prescription dated X indicating a request for a X. Based on the medical record, the injured worker sustained an injury X. The diagnoses were radiculopathy of the lumbar region and lumbar sprain/strain. The injured workers work status was undisclosed. Attempted treatments included X. An undated lumbar spine X-ray showed X. However, an MRI of the lumbar spine dated X revealed a X. Notably, an X. The X. Mild narrowing of the X was also noted. According to the initial report submitted by X, MD, dated X, the injured worker presented severe low back pain radiating

into the left lower extremity, accompanied by numbness and tingling. The pain was described as sharp, intermittent, and pressure-like and worsened with prolonged standing. Objective findings included X. The provider recommended a X. A subsequent progress report submitted by X, MD, dated X, noted that the injured worker continued to report throbbing pain rated at X and was able to perform approximately X of job duties. Pain was intermittent and worsened by bending or prolonged standing but stretching provided relief. No new symptoms were reported. The injured worker also experienced low back pain radiating into the right lower extremity. Physical examination revealed a X. The X. The provider is appealing the prior determination at this time. Regarding X. and performed X. They should have X. Other factors, including functional disability due to pain, X. The use of X is not recommended. Per submitted documentation, the request is not warranted. The referenced guidelines recommend X. The guidelines recommend the use of X. The use of X is not recommended. Based on the injured worker's clinical findings of a X. However, a recent progress report dated X documented significant functional improvement, with pain reduced to X, the ability to perform X of job duties, and no new or worsening symptoms. Furthermore, the requested X. Since the injured worker demonstrated clinical improvement and the request X not supported by current guidelines, the request is not medically necessary at this time to treat the lumbar condition. Therefore, the prospective request for X is non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The most recent office visit note submitted for review X. This note indicates that on physical examination X. Guidelines note that X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. X is not medically necessary and non-certified.

Upheld

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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