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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X; Amendment 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 is a X who sustained an injury on X. They sustained injury due X. The diagnoses included strain of lumbar region, lumbar spondylosis, and lumbar radiculopathy.

On X, X, FNP examined X for back pain. The pain was rated X. X reported increased muscle spasms in the left lower back. The pain was described as sharp, aching, and constant in the left thigh. X reported significant pain (moderate-to-severe pain for more than X months) and functional impairment. Examination of the lumbar spine revealed X were recommended.

X was seen by X, FNP / X, MD on X for a follow-up of low back pain. X stated the pain had increased in the past month. X was having muscle spasms to lower back and burning pain to the buttocks as well. The pain was located at the lower back radiating to bilateral lower extremities. The pain was described as sharp and lightning and rated X. The ongoing treatments and medications provided a pain relief at X. X had not seen Dr. X, X was wanting to X. The X was being denied even though a different approach was being ordered of X. X blood pressure was 129/89 mmHg and body mass index was 32.22 kg/m2. On examination, X gait was X. There was X.

X of the bilateral lower extremities dated X was X. There was some evidence of X. There was no significant evidence of X.

Treatment to date included X.

Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “Per the submitted documentation, the request for X is not warranted. As per the cited guidelines, subsequent X is indicated for injured workers with X. The injured worker reported back pain rated at X, with increased muscle spasms in the left lower back and sharp, aching, constant pain in the left thigh. They described moderate-to-severe pain persisting for over X months, leading to functional limitations. Lumbar spine exam revealed X. They underwent various

treatments including X. They reported X pain relief from X. A prior X on X yielded no relief, and they expressed interest in further X. An affiliated review on file for X was noncertified since the injured worker X. Although the injured worker had back pain with other clinical symptoms despite their X, the request is not medically necessary since their X on X. Therefore, the prospective request for X is non-certified."

Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: "Per the submitted documentation, the request for X is not warranted. As per the Official Disability Guidelines, subsequent x is indicated for injured workers with X. This treatment is indicated as the injured worker has experienced a recurrence of X. The X is X. The injured worker reported back pain rated at X, with increased muscle spasms in the left lower back and sharp, aching, constant pain in the left thigh. They described moderate-to-severe pain persisting for over X months, leading to functional limitations. Lumbar spine exam revealed X. They underwent various treatments including X. They reported X pain relief from current X. A prior X on X yielded no relief, and they expressed interest in further X. An affiliated review on file for X was non-certified since the injured worker did not X. A peer-to-peer discussion on X confirmed that the injured worker had X. Despite this, the request for a X was deemed not medically necessary. While the Official Disability Guidelines X. Therefore, the prospective request for X is non-certified."

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

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. The initial request was non-certified noting that, "Per the submitted documentation, the request for X is not warranted. As per the cited guidelines, X. The injured worker reported back pain rated at X, with increased muscle spasms in the left lower back and sharp, aching, constant pain in the left thigh. They described moderate-to-severe pain persisting for over X months, leading to functional limitations. Lumbar spine exam revealed X. They underwent various treatments including X. They reported X pain relief from, X. A prior X on X yielded no relief, and they expressed interest in further X. An affiliated review on file for X was

noncertified since the injured worker did not achieve the required level of pain and functional improvement following the X. Although the injured worker had back pain with other clinical symptoms despite their conservative treatments, the request is not medically necessary since their X on X. Therefore, the prospective request for X is non-certified." The denial was upheld on appeal noting that, "A peer-to-peer discussion on X confirmed that the injured worker had X. Despite this, the request for a X was deemed not medically necessary. While the Official Disability Guidelines X. 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. For X, guidelines require documentation of improvement in function after X as well as at least X improvement in pain. The patient received X on X. Per note dated X, X reports the X. X is no better. X were noted. Pain level was rated X. Note dated X indicates pain level was X. Note dated X indicates pain level was X. Note dated X states that X previously had X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is not medically necessary and non-certified.

Non-certified.

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**
- ☐ **X, 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)**