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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)

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 who was injured on X, while employed for X; X was X. The diagnosis was lumbar sprain, strain.

On X, X was re-evaluated by X, MD with respect to a work-related injury sustained while working on X. X stated X felt about the same, with X pain. X was able to do X of X job and had intermittent pain. X was following the treatment plan, which helped, but had been denied X in spite of meeting ODG. X had X in the past, which had helped significantly, with X or greater relief, able to stand longer, sleep longer, with decreased medication. Musculoskeletal examination revealed X. Flexion, extension, and rotation of the X. Straight leg raise was X on the left. There were paravertebral spasms of the X. The assessment was lumbar sprain, strain. Dr. X would appeal to IRO for the X and see X.

A X dated X, identified X. An MRI of the lumbar spine dated X, demonstrated X. X revealed X. At X, there was X. The spinal canal was X. The X revealed X noted, with the left foramen X. There was X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X, was denied by X, DO. Rationale: "The request is not medically necessary. Though the claimant has a history of ongoing pain due to work related injury, and it was noted that the claimant at X improvement with X, there was lack of documentation or clear evidence of the claimant having at least X of relief. Until there's additional information, it is not indicated in this case. Therefore, the request for the X is not medically necessary."

Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. Rationale: "The request is not medically necessary. Based on the documentation provided, the ODG (updated X)-Online version. X, is not satisfied. On X, the claimant sees Dr. X. The claimant had a prior X with benefit with up to X of benefit. The claimant had imaging. On examination, there is X. There is X to the left leg. Mechanism of injury is not known. Diagnosis X lumbar strain. Plan is for ongoing care. In particular, there is no documentation

that the X. Therefore the request for X is not medically necessary."

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 non-certifications are upheld. The initial request was non-certified noting that, "The request is not medically necessary. Though the claimant has a history of ongoing pain due to work related injury, and it was noted that the claimant at X improvement with X, there was lack of documentation or clear evidence of the claimant having at least X. Until there's additional information, it is not indicated in this case. Therefore, the request for the X is not medically necessary." The denial was upheld on appeal noting that, "Based on the documentation provided, the ODG (updated X)-Online version. X, is not satisfied. On X, the claimant sees Dr. X. The claimant had a X. The claimant had imaging. On examination, there is X. There is X. Mechanism of injury is not known. Diagnosis X lumbar strain. Plan is for ongoing care. In particular, there is no documentation that the X. Therefore the request for X is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. Guidelines require documentation of sustained improvement of pain or function of ≥ X, as measured from baseline, for ≥ X after X. In this case, the patient underwent X on the left on X. Prior to the X on X, the patient's pain was rated X. As of X, the patient's pain was X. There are no serial pain scores from the date of the X to the X note to support at least X improvement of pain. There are no objective measures of functional improvement provided. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is not medically necessary and 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**
- ☐ **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)**