MedHealth **R**eview, **I**nc.
422 Panther Peak Drive
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 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:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is at X who sustained an injury on X. The patient was diagnosed with intravertebral disc disorders with radiculopathy, lumbar region, muscle spasm of the back and sprain of ligaments of lumbar spine. The patient sustained a lower back injury while X. Treatment included X. Despite ongoing treatment, the patient continued to experience pain and limited range of motion, affecting daily activities and X.

On X, X, MD evaluated the patient in the emergency room for acute back pain, prescribing X.

On X to X X, MD evaluated the patient for a lower back injury sustained while X. The patient reported severe lower back pain, radiating to the buttocks, right shoulder, and knee, with limited range of motion, difficulty with daily activities. Physical examination revealed X. Treatment included X. An MRI was ordered due to symptoms inconsistent with the injury.

On X, MD reported X.

On X, MD evaluated the patient for a lumbar strain, noting X.

On X, DC evaluated the patient for a workplace injury involving lower back pain with ridiculous symptoms. Patient was initially referred for X. In subsequent evaluations, the patient had X, but not approved by insurance. The physician recommended X. Later, the patient was referred for X, reporting, continuous pain, depression, and limitations and daily activities.

On X, PTA provided X to the patient of multiple sessions. The treatment focused on X. The patient reported pain levels

of X during treatment, with a slight increase in back pain noted during one session. Improved hamstring extensibility was observed, and the plan was to continue treatment as scheduled. The X and addressed pain affecting activities of daily living.

On X, X conducted a X for the patient, focusing on various body areas, including the neck, back, and extremities. The treatment involved X.

On X, X, PT conducted multiple X for the patient. The treatments included X. The patient initially reported left pain after X. That therapist utilized X

On X, X, PT conducted a X with the patient, who reported pain levels of X various treatments, X.

On X, X documented that the patient, who sustained lower back injury previously, is participating in a X.

On X, the patient, who sustained a lower back injury previously was participating in a X. The patient X.

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

Criteria for the general use of multidisciplinary pain management programs:
Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

X.

Per evidence-based guidelines, and the records submitted, this request is non-certified. The patient sustained a lower

back injury while X. Treatment included X. Despite ongoing treatment, patient continued to experience pain and limited range of motion, affecting daily activities and leading to a X. This patient has X. Guidelines recommend up to X. In this case, the patient has X to determine if additional are medically necessary currently. The request for X. Given that, it is not appropriate to consider X. Therefore, the requested X, is not medically necessary.

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

☐ 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY 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)**