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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. X was X. X stated X was trying to open the door. When X was pulling X. The diagnoses were (X) low back pain, unspecified and (X) unspecified fracture of unspecified lumbar vertebra, initial encounter for closed fracture. On X, X was seen by X, MD, for evaluation of chief complaint of low back pain. X presented for evaluation of X back. The previous year, X. X had gotten back to where X could return to work. X was X. X stated X was trying to open the door. When X was pulling on the door, X fell backwards and landed on X back. Since then, X had intractable back pain. X had an MRI, which was reviewed with X that day, which showed an X. X had been placed in a X. Despite this and using a walker, X had been very symptomatic. X had been unable to return to work and had a very difficult time doing normal activities of daily living (ADL's). The pain was X. It was severe with the worst pain rated X. It was aggravated with standing, walking, lifting, carrying, twisting, bending, and squatting. Nothing helped. Associated symptoms included weakness and numbness. On examination, weight was 265 pounds and body mass index (BMI) was 42.8 kg/m2. Gait and station examination revealed a limp, antalgic gait, and ambulating with walker. Lumbar spine showed X. Tenderness was noted of the X. The range of motion of lumbar spine was decreased. X was very uncomfortable during examination. No weakness was noted. The motor strength of the lower extremities was intact, bilaterally, X. X was scheduled for X. X was unable to work at that point. After a X. An MRI of the lumbar spine dated X demonstrated a X. There was X. This finding was seen on the previous CT scan of the lumbar spine from X. Postoperative changes were seen at X. There were multilevel degenerative changes as follows: At X, there was mild loss of disc height. There was X. X were patent. At X, there was mild loss of disc height.

There was X. There was a X. There was X. The X. At X, there was X. There was X. The X. At X, there was moderate loss of disc height. There was a X. There was X. There was X. There was X. The right neural foramen was patent. At X, there was a X. There was X noted. There was X noted. There was X. X was patent. There was X. At X, there was X. There was X. There was X. There was X. X was patent. There was X. The X was patent. There was a X. There was a X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "ODG notes that X. There must be X. In this case, the records do not reveal any history X. Therefore, the requested X is not medically necessary. "Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Official Disability Guidelines (ODG) notes that X. There must be X. In this case, current evidence-based guidelines support X. The records show no evidence that X. Thus, the requested X is not medically necessary. "Based on the submitted documentation, the claimant sustained a X. This occurred on X. The records do not reflect X. Furthermore, the mechanism of injury described a X. No new information has been provided which would overturn the previous denials. 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:

Based on the submitted documentation, the claimant sustained a X. This occurred on X. The records X. Furthermore, the mechanism of injury described a X. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.
Upheld

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)**