

IRO Certificate No: X

Notice of Workers' Compensation Independent Review Decision

This document contains important information that you should retain for your records.

Coverage Type:

- Workers' Compensation Health Care Network
- Workers' Compensation (non-network) if applicable, decision must include specific basis for divergence from TDI/DWC policies or guidelines

Type of Review:

- Preauthorization Review
- Concurrent Review
- Retrospective Review

Prevailing party (if applicable)

- Requestor
- Carrier

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY: This is a case of a now X. The mechanism of injury was not detailed in the records for review. The diagnoses of the patient are radiculopathy of the lumbosacral region and other intervertebral disc displacement of the lumbar region. The comorbid conditions were documented as X. The MRI dated X, revealed X. The X Progress note indicates the patient complains of lower back pain radiating to the left leg. There is a reduction in range of motion, left leg weakness and positive tension sign on the left leg only. The patient has been taking X. These progress notes indicate the goal is to have the patient return to work. If conservative care is unsuccessful, the patient is a possible surgical candidate. The notes indicate the patient has had X. The patient requested to proceed with X. The denial letter indicates that the documentation does not support that the patient has X. This review pertains to the request for X.

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

The Official Disability Guidelines Low Back guidelines regarding X. The prior request for X was denied in this case as there was no documentation received of X. The X progress

note only stated that the patient had X. There were no actual physical therapy progress notes submitted for review. Therefore, the request for X is not medically necessary.

SOURCE OF REVIEW CRITERIA:

- 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 Judgment, Clinical Experience, and Expertise in Accordance with Accepted Medical Standards

- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG- Official Disability Guidelines & Treatment 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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)

ATTESTATIONS: X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X