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Notice of Independent Review Decision

Sent to the Following

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: URA Records

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was X. The X. X felt immediate pain in X entire spine including X neck and low back. X also noted right shoulder pain. X was found to have X. The diagnosis was low back pain; both upper lumbar and lower lumbar; L1 superior endplate fracture with 25% loss of vertebral height; and diminished signal central protrusion and posterior central tear at L4-L5.

On X, X presented to X, MD for follow-up with the chief complaints of neck pain, right trapezial pain; low back pain; and X. X was injured at work on X when X was X. The X. X felt immediate pain in X entire spine including X neck and low back. X also noted right shoulder pain. X was taken by X. X was found to have an X. X was placed in a X. X had continued to complain of low back pain. X also continued to complain of neck and right trapezial pain. Since the X visit, the neck pain was better. X continued to have right shoulder pain. X continued to complain of low back pain over the upper lumbar region approximately at X. Complete neurological examination revealed X was in obvious pain. X was very slow in going from a sitting to a standing position secondary to low back pain. X was tender to palpation over the right trapezius. X was tender to palpation to the lumbar spine. Range of motion of the cervical spine revealed flexion X degrees, extension X degrees, and rotation of X degrees to the left and to the right. Range of motion of the lumbar spine revealed flexion X

degrees, extension X degrees which produced low back pain and lateral bending X degrees to the left and to the right. Facet signs were X. Motor exam revealed X strength in all upper and lower extremity muscle groups. Sensory exam was intact to pinprick. Reflexes were X. Review of MRI scan of the lumbar spine dated X revealed an X. At X. Review of MRI scan of the cervical spine dated X revealed at X. Review of MRI scan of the right shoulder dated X. The assessment was low back pain; both upper lumbar and lower lumbar; X. X had already been referred to an orthopedic surgeon to evaluate X right shoulder. For X lower lumbar pain, Dr. X recommended X.

An MRI of the lumbar spine dated X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X, was denied by X, MD. Rationale: “Per ODG guidelines, "X." Based on a recent visit the claimant had low back pain. Examination of lumbar spine revealed tenderness to palpation over spine. The range of motion of the lumbar spine revealed flexion to X degrees, extension to X degrees which produced low back pain and lateral bending to X degrees to the left and to the right. Facet signs were X. Reflexes were X. An MRI of lumbar spine dated X showed X. There was an X. There was no evidence of radicular pain. As such, the request for X, is not medically necessary.”

In a letter of appeal dated X, Dr. X wrote, “This is a Letter of Appeal on patient, X who was injured in a work-related accident on X. A X. Patient felt immediate pain in the entire spine including X neck and low back. X was actually found to have an X. X has continued to complain of low back pain. MRI Scan lumbar spine dated X reveals an X. At X. On X, we recommended a X. Unfortunately, the X was denied. There is no rational basis for this denial. Patient meets all the criteria invented for someone that needs a X. We would like to therefore appeal this denial.”

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “ODG states that X is recommended if X. Based on available records, the claimant had continued to complain of low back pain. X continued to complain of low back pain. There was one over the upper lumbar region approximately at X. The examination of lumbar spine revealed tenderness to palpation (TTP) over spine. The range of motion (ROM) of the lumbar spine revealed flexion to X degrees, extension to X degrees which produced low back pain, and lateral bending to X degrees to the left and to the right. Facet signs were X. Reflexes were X. Reviewed MRI of lumbar spine dated X showed X. At X. There is no radicular pain. There is no evidence of trial / failure of conservative care options. As such, the request for Appeal request for X is not medically necessary.”

Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews.

Patient with pain in potentially radicular distribution that has continued despite proper conservative treatment. Given corresponding imaging findings, request for X is medically necessary and certified

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

Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews.

Patient with pain in potentially radicular distribution that has continued despite proper conservative treatment. Given corresponding imaging findings, request for X is warranted based on cited guidelines. X is medically necessary and 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)