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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 at work on X. The mechanism of injury was described as lifting injury at work. The diagnosis was sprain of ligaments of lumbar spine, initial encounter (X).On X, X was evaluated by X, MD for low back pain radiating to the right lower extremity. A CT scan of the lumbosacral spine revealed X. X had a X. At the time, X was able to stand for less than X minutes, able to sit for more than X minutes, and able to walk for less than X minutes. Pain level was X at the time, X at worst, and X at best. X reported the pain felt like throbbing, aching, pressure that traveled down to the right leg. X had some tingling in the toes of X right foot. X stated the X. X had undergone a Designated Doctor Evaluation and was noted to be not at X. Lumbar examination revealed X. Motor strength in the lower extremities was X on the right. Straight leg raise was X on the right and on the left. Sensory deficit was noted in the right X and X dermatomes. The assessment was X.A CT scan of the lumbar spine dated X, demonstrated X. The findings revealed X and X at X and X. The X level revealed X. The X level revealed X. The X and X revealed X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for right X was denied by X, MD. Rationale: “ODG by MCG does not address the request for X. Alternate chapter cited: ODG y MCG Last review/update date: X X: X; may be a first-line or second-line option. ODG Criteria X may be indicated when ALL of the following are present (X. Procedure performed X: X or X. o Procedure performed under X is NOT recommended for any of the following (3): X X X" In this case, the X appears to be incomplete but states that there is X. There is no record of diagnostic imaging that would explain right lower extremity symptoms. The request is not shown to be medically necessary. Therefore, the request for the X is non-certified. “Per a reconsideration review adverse

determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “The request s not medically necessary. Based on the documentation provided, the ODG (updated 8)-Online version, X, is not satisfied. In particular, there is no documentation of an updated, significantly abnormally examination, and significantly abnormal corroborative diagnostic studies. Therefore, the Appeal: X is not medically necessary. “Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews. The patient has pain in potentially radicular distribution that has continue despite conservative treatment. While the patient cannot get an X. Instead, further corroborating evidence should be considered prior to considering X. There is no documentation of consideration for X. Given unclear if there is a corresponding pathology that can explain patient’s pain, request for X is not warranted. 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:

Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews. The patient has pain in potentially radicular distribution that has continue despite conservative treatment. While the patient cannot get an X, a X cannot be considered as a X. Instead, further corroborating evidence should be considered prior to considering X. There is no documentation of consideration for X. Given unclear if there is a corresponding pathology that can explain patient’s pain, request for X is not warranted. 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)**