Independent Resolutions Inc.
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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 Overturned Agree in part/Disagree in part

☐ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who injured X lower back at work on X due to X. X reported X was X. X reported the pain progressively got worse. The diagnosis was strain of muscle, fascia, and tendon of lower back; and sprain of ligaments of lumbar spine.

On X, X was evaluated by X, MD with the chief complaint of low back pain radiating to the left lower extremity. X reported X was able to stand for less than X minutes, able to sit for less than X minutes, and able to walk for less than X minutes. The pain level was X at the time, X at the worst, and X at best. X described the pain as soreness and aching pain and stated the procedure helped some of the pain. X reported improvement in overall pain by more than X after the procedure (X), and X was able to stand longer, sit longer, walk longer, sleep better, decrease pain medication, and had less stress. X stated X was having pain again and would like another X. There were no significant changes in the physical examination since the office visit dated X, which showed the following examination findings: Examination noted interspinous tenderness in the thorax. Motor strength in the left lower extremity was X. There was sensory deficit in the X. Straight leg raise was positive on the left. There was X. The assessment was strain of muscle, fascia, and tendon of lower back, initial encounter; and sprain of ligaments of lumbar spine, initial encounter. Dr. X ordered a X. X communicated a willingness for X. X understood it was important to minimize sudden

movement during the procedure. X expressed a X. Dr. X noted that per the American Society of Anesthesiologists Guidelines, X was a candidate for X. X was willing to proceed with the proposed procedure for the purpose of improving function and decreasing pain.

An MRI of the lumbar spine dated X, demonstrated 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: “The request is not medically necessary. Based on the documentation provided, the ODG (updated X, is not satisfied. In particular, there is no documentation of an updated detailed physical examination since X. Therefore, the X is not medically necessary.”

Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. Rationale: “The request is not medically necessary. In this case, the claimant reported low back pain. The pain radiates into the left upper extremity. The MRI showed severe X. The claimant experienced over X pain relief and functional improvement following the X. However, there is no documentation of physical examination on the recent visit note to warrant the request of X. As such, this request is not supported at this time. Therefore, the X is not medically necessary.

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

The ODG states that X. The recent notes for past visits cite no new change in exam since prior visit. The last visit that had the actual exam documented (without referring to a prior examination) appears to be X. Just because the examination findings did not change, does not mean an exam was not done or not documented. Thus, given continued pain in potentially radicular distribution, combined with imaging findings, as well as X. 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 findings, and peer reviews.

The ODG states that X. Lumbar radiculopathy by history (e.g., radiation of pain and numbness along the distribution of the affected spinal root), and ALL of the following: Diagnostic imaging (e.g., CT scan, MRI) correlates with symptoms, and X. The recent notes for past visits cite no new change in exam since prior visit. The last visit that had the actual exam documented (without referring to a prior examination) appears to be X. Just because the examination findings did not change, does not mean an exam was not done or not documented. Thus, given continued pain in potentially radicular distribution, combined with imaging findings, as well as prior successful X. X is medically necessary and certified.

Overturned

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

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☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE