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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)

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 sustained an injury on X. The diagnoses included lumbar radiculopathy, thoracic region radiculopathy, headache, and low back pain. Please note that there are X. Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: "In this case, the patient is a X-year-old individual with a date of injury of X. The injury was sustained when the patient X. Per the progress report dated X, the patient rates their pain level as a X. The patient X. The patient reports X. The patient reports aggravating factors include prolonged standing, walking, bending, increased activity, and changes in the weather. Examination of the X. Prior treatment includes X. The prescription monitoring program report did not show any aberrant behavior. The previous urine drug screen (UDS) was compliant with the medications prescribed. Presumptive urine drug screen (UDS) done on X. Regarding the current request, the ODG guidelines for X. Per ODG, "Before initiating X. Realistic expectations and limitations of X should be discussed." In addition, "Ongoing assessment should continue to include pain and function outcomes, as well as progress towards treatment goals. This should be documented. A lack of clinically meaningful improvement in function is a reason for discontinuing X." Objective functional gains from ongoing use and treatment goals are not specified in the records in meaningful detail. Furthermore, it is unclear X. The request is not shown to be medically indicated. Therefore, the request for X is not medically necessary. Non-certification does not imply the abrupt cessation of a medication that may need to be weaned by the provider. "Per an utilization review by X, MD on X, an appeal request for X was upheld. Rationale: "I am recommending upholding the request for Appeal: X, for the following reasons: In this X claimant, the examination notes on X demonstrate complaints of pain in the lower back. Prior treatment includes X. The prescription monitoring program report X. The previous urine drug screen (UDS) was X. Presumptive urine drug screen (UDS) done on X. The physical examination reveals X. X intact in both upper extremities. X in both lower extremities. The request was non-certified by X M.D. on X due to as, it is unclear X. Per ODG by MCG, X notes that this X. While the claimant has X is documented, the record does not establish the use of a X. Additionally, there is no documentation of a X. Therefore, medical

necessity for X is not supported per ODG criteria. As such, the request is recommended upheld. "There were no supporting medical records to review that would justify the use of X as prescribed for this claimant. Therefore, it is this reviewer's opinion that the service in dispute: X is not medically necessary and the prior denials are upheld.

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

There were no supporting medical records to review that would justify the use of X as prescribed for this claimant. Therefore, it is this reviewer's opinion that the service in dispute: X is not medically necessary and the prior denials are upheld.

Non-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)