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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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 is a X who was injured at work on X, when X. The diagnoses were low back pain; radiculopathy in the lumbar region; radiculopathy in the cervical region; occipital neuralgia; myalgia, other site; and long-term (current) use of opiate analgesics. On X, X was seen by X, PA / X, MD for follow-up evaluation of low back pain. On the day, pain was rated X. X suffered from X. X underwent X to address the injuries sustained. Given X complaints of worsening back pain with pain and numbness into X left thigh along the anterolateral aspect as well as difficulty remaining active, X underwent a X on X with X relief from the procedure for X months. X reported improved functioning and was able to walk for longer distances without pain interference and improvement in X sleep. X was also able to reduce the amount of X. X continued with X. X updated lumbar MRI demonstrated X. X would like to avoid X, and a X was performed on X with greater than X improvement of X back pain and left leg pain following this procedure for over X months. A X only was performed on X with X relief. X was able to discontinue X, given X improvement and reported improved sleep and functioning. X was able to walk for longer periods of time and was "on (X] feet more." However, X back and left leg pain had begun to return, and X would like to schedule a X. X head and neck were injured in X work-related accident. X complained of X. X admitted to restricted range of motion in the cervical spine with pain experienced only on the left with radiation into the left shoulder. X complained of X. X obtained a cervical MRI to evaluate these complaints, which demonstrated a X. X had never undergone treatment for X neck pain with radicular pain into the left shoulder and would like to submit a request for a X. X stated without X pain medication, X pain score on a

VAS scale was increased to X and was reduced to X with X medications. The cervical spine examination revealed X. X was tender to palpation, X. The trigger point in X was noted. Spurling's test was X to the right and X to the left at neck. Tinel's sign was X. The strength was X at left X. Lumbar spine examination revealed X. The strength at right quadriceps and right hamstring was X; the strength at left quadriceps and left hamstring was X. Left lower extremity showed X. The straight leg raise (SLR) at left lower extremity was positive at X degrees. Treatment plan was to proceed with X. On X, X was seen by X, MD for follow-up evaluation of chief complaints of low back pain, and cervical and lumbar region radiculopathy. Regarding low back pain, X described X pain as shooting, stabbing, burning and numbness. It was described as moderate / worse that day. The pain was rated X. Pain sometimes interfered with X sleep. That day, X presented for further evaluation and management and complaining of pain to the lumbar spine radiating down the left leg. It was constant, severe, radiating, and aching. It improved with treatment and was better with medicines. Regarding cervical radiculopathy, X was complaining of pain to the cervical spine radiating down the left shoulder. At the time, it was rated X. The physical examination was unchanged since the prior visit except for the exceptions noted below. There were no X. Cervical and lumbar range of motion for extension and flexion, and there was no significant change. The reflexes were the same as on the previous examination at the X. There were no new X. Treatment plan was to proceed with X An MRI of the cervical spine dated X revealed X. An MRI of the lumbar spine dated X revealed X. At X, there was X. No updated MRI's were available. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X; X; X was denied by X, MD. Rationale for denial of X "Per ODG, "X may be indicated when ALL of the following are present X." In this case, there is X. As such, the request for X is not medically necessary." Rationale for denial of X: "Per ODG, "X." In this case, there is X. As such, the request for X is not medically necessary." Rationale for

denial of X: “Per guidelines, "X should be used only X." Also, "If the X does not provide a response with temporary and sustained pain relief (at least X weeks) substantiated by accepted pain scales (i.e., X pain reduction as measured by tools such as VAS) and improvement in function, X are not recommended...A X result (X) should include X." In this case the previous X in X yielded X relief. However, the duration of that relief is unclear. As such, the request for X is not medically necessary. “Per a reconsideration review adverse determination letter dated X, the appeal request for X; X; X; was denied by X, DO. Rationale for denial of X: “Per ODG by MCG, X recommended as an option; may be a X. X may be indicated when X. In this case, the claimant had pain in lumbar spine radiating down to left leg. X rated pain as X. X described X pain as shooting, stabbing, burning, and numbness. On examination, X body mass index (BMI) was 33.7 kg/m2. An MRI of the lumbar spine dated X revealed X. At X, there was X. The claimant had X on X, but the documentation did not show the duration of the relief. As such, the Appeal request for X, is not medically necessary.” Rationale for denial of X: “Per ODG by MCG, X recommended as an option; may be X. X may be indicated X. In this case, the claimant had pain in lumbar spine radiating down to left leg. X rated pain as X. X described X pain as shooting, stabbing, burning, and numbness. On examination, X body mass index (BMI) was 33.7 kg/m2. An MRI of the cervical spine dated X revealed X. There is X. As such, the Appeal request for X, is not medically necessary.” Rationale for denial of X: “Per ODG by MCG, X recommended as an option; may be a X. X may be indicated when X. In this case, the claimant had pain in lumbar spine radiating down to left leg. X rated pain as X. X described X pain as shooting, stabbing, burning, and numbness. On examination, X body mass index (BMI) was 33.7 kg/m2. An MRI of the cervical spine dated X revealed X. There is X. As such, the Appeal request for X, is not medically necessary. Based on the clinical information provided, the request for X; X; X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review

adverse determination letter dated X, the request for X; X; X was denied by X, MD. Rationale for denial of X: “Per ODG, "X may be indicated when ALL of the following are present X." In this case, there is X. As such, the request for X is not medically necessary.” Rationale for denial of X: “Per ODG, "X may be indicated when ALL of the following are present X." In this case, there is X. As such, the request for X is not medically necessary.” Rationale for denial of X: “Per guidelines, "X should be used only after X." Also, "If the X does not provide a response with temporary and sustained pain relief (at least X weeks) substantiated by accepted pain scales (i.e., X pain reduction as measured by tools such as VAS) and improvement in function, X are not recommended...A X result (X) should include X." In this case the previous X in X yielded X relief. However, the duration of that relief is unclear. As such, the request for X is not medically necessary.” Per a reconsideration review adverse determination letter dated X, the appeal request for X; X; X; was denied by X, DO. Rationale for denial of X: “Per ODG by MCG, X recommended as an option; may be a X. X may be indicated when X. In this case, the claimant had pain in lumbar spine radiating down to left leg. X rated pain as X. X described X pain as shooting, stabbing, burning, and numbness. On examination, X body mass index (BMI) was 33.7 kg/m2. An MRI of the lumbar spine dated X revealed X. At X, there was X. The claimant had X on X, but the documentation did not show the duration of the relief. As such, the Appeal request for X, is not medically necessary.” Rationale for denial of X: “Per ODG by MCG, X recommended as an option; may be a X. X may be indicated when X. In this case, the claimant had pain in lumbar spine radiating down to left leg. X rated pain as X. X described X pain as shooting, stabbing, burning, and numbness. On examination, X body mass index (BMI) was 33.7 kg/m2. An MRI of the cervical spine dated X revealed X. There is X. As such, the Appeal for X, is not medically necessary.” Rationale for denial of X: “Per ODG by MCG, X recommended as an option; may be a X. X may be indicated X. In this case, the claimant had pain in lumbar spine radiating down to left leg. X

rated pain as X. X described X pain as shooting, stabbing, burning, and numbness. On examination, X body mass index (BMI) was 33.7 kg/m2. An MRI of the cervical spine dated X revealed X. There is X. As such, the Appeal request for X, is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. Per ODG, "X may be indicated when X." In this case, there is X. As such, the request for X is not medically necessary." Rationale for denial of X: "Per ODG, "X may be indicated when X." The claimant X on X. Although it is reported that X had X pain relief, X VAS score only decreased from X to X. There are no objective measures of improvement. It is unclear what X the claimant has had for the cervical spine. There is no significant neuro-compressive pathology on cervical MRI. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X; X; X are not medically necessary and non-certified

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

Based on the clinical information provided, the request for X; X; X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X,X; X; X was denied by X, MD. Rationale for denial of X: "Per ODG, "X may be indicated when X." In this case the previous X in X yielded X relief. However, the duration of that relief is unclear. As such, the request for X is not medically necessary." Per a reconsideration review adverse determination letter dated X, the appeal request for X; X; X; was denied by X, DO. Rationale for X: "Per ODG by MCG, X recommended as an option; may be a X. X may be indicated when X. In this case, the claimant had pain in lumbar spine radiating down to left

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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)**