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# Notice of Independent Review Decision

**IRO Reviewer Report**

**X**

**IRO Case Number: X**

**Description of the services in**

**dispute**

X

**Description of the qualifications for each physician or health care provider who reviewed the decision**

X.

**Review Outcome:** Upheld

Provide a description of the review outcome that clearly states whether **medical necessity exists**
for **each** of the health care services in dispute.

X

**Patient clinical**

**history**

X individual diagnosed with low back pain and other intervertebral disc displacement in the lumbar region and seeking coverage for X. The claimant was injured on X due to an unknown mechanism of injury. The claimant presents with diagnoses of low back pain and other intervertebral disc displacement in the lumbar region. No comorbidities are noted. Office visit note dated X indicates that the claimant reports pain down the right lateral thigh and buttock area. The claimant has a X. The throbbing, persistent pain in the right buttock and leg continues to be problematic anteriorly. X is recommended for a X. CT myelogram lumbar spine dated X revealed X. Follow-up note dated X indicates that X has X. Follow-up note dated X indicates that the claimant presents for X. X has developed new pain down her right lateral thigh and buttock area. X is recommended for a X. CT lumbar spine dated X shows at X. The bony dimensions of the spinal canal are adequate. At least moderate X is present on the right, and there is mild to moderate X on the left as well as X. Note dated X indicates motor strength is X except for right ankle dorsiflexion and right great toe extension, which are X. Reflexes are X bilaterally, and sensation is intact throughout. Note dated X indicates X has back pain above the previous surgical site at the X. Note dated X indicates pain is X.

**Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision**.

According to the Official Disability Guideline (ODG), X is conditionally recommended when the member has had X. X is not recommended for X.

In this case, the claimant reports new pain radiating down the right lateral

thigh and buttock. A CT myelogram demonstrated an X. However, the record does not document objective clinical findings consistent with X. Neurologic examination findings show intact sensation in all extremities, deep tendon reflexes of X bilaterally at the patella and Achilles, and no documented sensory or motor deficit in a dermatomal or myotomal distribution. Additionally, there is no documentation of recent X. The claimant currently has a X. Furthermore, no clinical justification was provided for the use of X.

Therefore, the requested procedure does not meet evidence-based guideline criteria for medical necessity due to the absence of documented X. Based on the clinical information provided, the request for X is not recommended as medically necessary, and the denial is upheld.

**Description and source of the screening criteria or other clinical basis used to make the decision**

ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase

AHRQ - Agency for Healthcare Research and

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

**ODG - Official Disability Guidelines & Treatment 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)