MET HEALTHCARE SOLUTIONS
2211 West 34th St. ● Houston, TX 77018
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

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

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

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

The claimant is a X diagnosed with other intervertebral disc displacement lumbar region, radiculopathy, lumbar region, and sprain of ligaments of the

lumbar spine. This review is to determine the medical necessity of the prospective request for X.

The denial letter from X dated X stated that, “This request was previously non-certified twice due to X. A prior request for X was non-certified in review X on X due to X. Furthermore, the request for X was previously non-certified in review X dated X, to the absence of X. The provider's appeal makes no mention of the non-certification of review X. There is no updated report submitted for review. X notes were attached instead. Based on prior review, the claimant had a follow up visit on X with complaints of persistent low back pain. Physical exam showed X. Prior treatments were X. The provider is appealing the prior determination at this time.” Additionally, the denial letter dated X stated that, “The Official Disability Guidelines recommend X. The procedure is performed X. The claimant is complaining of persistent low back pain. The assessment showed X. This request was previously non-certified X. No new information was provided. The guideline requires at least X improvement of pain or function with objective measures noted for at least X weeks. Thus, the appeal request for X is non-certified.”

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

The claimant is a X diagnosed with other intervertebral disc displacement lumbar region, radiculopathy, lumbar region, and sprain of ligaments of the lumbar spine. This review is to determine the medical necessity of the prospective request for X.

Under the Official Disability Guidelines (ODG), X. Although this claimant has objective findings consistent with X. In the absence of documented objective improvement, ODG does not support X does not meet medical necessity criteria at this time.

Therefore, it is the professional opinion of the medical reviewer to uphold the denial of the prospective request for X due to a lack of medical necessity. This means that the claimant will not receive coverage for the requested procedure.

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