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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 was injured on X. X was injured at work. The diagnosis was other intervertebral disc displacement, lumbosacral region and sprain of ligaments of lumbar spine, subsequent encounter. On X, X,

MD performed X. The postoperative diagnosis was X. On X, X, MD evaluated X for a postoperative visit. X was X weeks out. X continued to complain of axial back pain. X wounds were improving. X continued on X for pain control. Lumbar spine examination revealed X. X anteriorly healing had improved, still a small area of punctate drainage anteriorly, but it appeared significantly improved. Motor and sensory examination was X. X-rays of the lumbar spine obtained on the same date revealed X. X was progressing well but continued to complain of postoperative pain. X was continued. X was prescribed for pain control. An MRI of lumbar spine dated X revealed X. There were X. There was a X. At X, there was X. There was X on the left side into the X. This contacted the descending left X. At X, there was X. At X, there was X. At X, there was 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: "Guidelines recommend X. X are NOT recommended for X. In this case, the individual is noted to be X dated X. Although the individual is noted to be , this is noted to be a X. It is noted that the individual was noted to be a current X dated X and there is no indication of the X. Considering the lack of documentation noting any associated risk factors for X, medical necessity cannot be established." Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Guidelines recommend X. X are NOT recommended for X. In this case, a prior utilization review decision dated X is for the non-certification of the requested X. An appeal letter dated X states that the goal of this reasonable and medically necessary X is to provide pain relief, increase performance and the activities of daily living, reduce symptoms and reduce medication use. However, this appeal letter appears to be in relation to a requested X, as there is no rationale provided as to how the X. Additionally, this is a X. There is also no clear documentation of the individual's current X. Of note, the carrier disputes the compensable injury extends to or includes any other body part or diagnosis including spinal canal stenosis at X and X, as well as X. Given that this is a X is not medically necessary or appropriate."

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

The requested X is not medically necessary. The submitted records indicate that the patient underwent a X. There is no documentation that this was a X. There is X. There is no evidence of X. No new information has been provided which would

overturn the previous denial. The requested X is not medically necessary.

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)