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Notice of Independent Review Decision

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 Overtuned (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 was injured on X, while employed for X. as a X; X was X. The diagnosis was lumbar sprain, strain.

On X, X was re-evaluated by X, MD with respect to a work-related injury sustained while working on X. X stated X felt about the same, with X pain. X was able to do X of X job and had intermittent pain. X was following the treatment plan, which helped, but had been denied X in spite of meeting ODG. X had X in the past, which had helped significantly, with X or greater relief, able to stand longer, sleep longer, with decreased medication. Musculoskeletal examination revealed X. Flexion, extension, and rotation of the lumbosacral spine was decreased X in all planes. Straight leg raise was X on the left. There were paravertebral spasms of the X. The assessment was lumbar sprain, strain. Dr. X would appeal to IRO for the X and see X back in a X.

A X dated X, identified X. An MRI of the lumbar spine dated X, demonstrated X. At X, there was X. The spinal canal was X. The X revealed 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, DO. Rationale: “The request is not medically necessary. Though the claimant has a history of ongoing pain due to work related injury, and it was noted that the claimant at X improvement with X, there was lack of documentation or clear evidence of the claimant having at least X weeks of relief. Until there’s additional information, it is not indicated in this case. Therefore, the request for the X is not medically necessary.”

Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. Rationale: “The request is not medically necessary. Based on the documentation provided, the ODG (updated X)-Online version. X, is not satisfied. On X, the claimant sees Dr. X. The claimant had a X with benefit with up to X weeks of benefit. The claimant had X. On examination, there is X. There is X. Mechanism of injury is not known. Diagnosis X lumbar strain. Plan is for ongoing care. In particular, there is no documentation that the X resulted in

at least X pain reduction for X weeks. Therefore the request for X is not medically necessary."

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 is not recommended as medically necessary and the previous non-certifications are upheld. The initial request was non-certified noting that, "The request is not medically necessary. Though the claimant has a history of ongoing pain due to work related injury, and it was noted that the claimant at X improvement with X, there was lack of documentation or clear evidence of the claimant having at least X weeks of relief. Until there's additional information, it is not indicated in this case. Therefore, the request for the X is not medically necessary." The denial was upheld on appeal noting that, "Based on the documentation provided, the ODG (updated X)-Online version. X, is not satisfied. On X, the claimant sees Dr. X. The claimant had a X with benefit with up to X weeks of benefit. The claimant had X. On examination, there is reduced X. There is X. Mechanism of injury is not known. Diagnosis X lumbar strain. Plan is for ongoing care. In particular, there is no documentation that the X resulted in at least X pain reduction for X weeks. Therefore the request for Appeal X is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. Guidelines require documentation of sustained improvement of pain or function of ≥ X, as measured from baseline, for ≥ X weeks after X. In this case, the patient underwent X on X. Prior to the X on X, the patient's pain was rated X. As of X, the patient's pain was X. There are no serial pain scores from the date of the X to the X note to support at least X improvement of pain. There are X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is not medically necessary and 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)**