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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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X
PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was at work X. X reported X was X. The diagnoses were low back pain, unspecified (X); strain of muscle, fascia, and tendon of lower back (X); contusion of left knee (X); contusion of right knee (X); contusion of right hand (X); and contusion of left hand (X).On X, X was seen by X, NP when X presented for a follow-up of left lower extremity pain with onset on X. The pain was aching in quality and rated X in severity. This was

the result of a X; X had worked with restrictions and had X. X reported X. X was taking X. Examination was significant for X. The diagnoses were contusion of bilateral knees, contusion of bilateral hands, and strain of muscle, fascia, and tendon of lower back. X was to continue with X. Per a X visit note dated X by X, PT, DPT / X, PT, X reported X. All pain locations improved with rest and lying down. X reported X hands were still stiff at work and recently had a follow-up with X referring physician who wanted X to attend X. It was assessed that X progress towards goals and X tolerance to treatment was fair and X would benefit from X. X was X. In a letter dated X, X, Clinical X noted, "X has been prescribed the X by X healthcare provider, X to address X back condition. During examination, X noted that X experienced weakness and reduced strength in X lumbar spine, which has led to a decline in X functional mobility. X reports constant, severe low back pain. This pain is exacerbated by sustained activities such as sitting or standing for more than an hour, or walking for over an hour. Despite undergoing extensive X since X injury, X has not seen any positive results. X outlines several reasons supporting the use of the X: 1. X persistent low back pain is consistently rated at X, fluctuating in intensity but remaining severe on both better and worse days. 2. X suffers from significant low back pain, frequently to the extent that it prevents X from completing tasks and sometimes makes getting out of bed hard. 3. X low back pain restricts X ability to navigate stairs, run errands, and walk for at least X minutes. 4. X low back pain sometimes prevents X from X. X notes confirm objective findings: a significant extent of decreased range of motion in X back and weakness with reduced strength of the lumbar extensor muscles. These comprehensive findings align with the ODG criteria for utilizing the X: • The X. • The X offers X. Please consider this information when making a decision regarding the authorization of the X. We are confident that this intervention will significantly contribute to X recovery and overall well-being." Per a patient survey / interview for preauthorization dated X, X highest score was X, lowest score was X, and patient score was X. Per a X re-evaluation dated X by X, PT, it was assessed that X had been treated for X for bilateral hand, bilateral knee, and low back pain (LBP) and reported significant improvement in knee pain with X bilateral knee flexion and extension strength; however, X continued to report bilateral hand and LBP limiting X tolerance to work tasks and demonstrated impaired bilateral grip strength, bilateral digit flexion range of motion (ROM), bilateral hip abduction and extension strength, and lumbar ROM. It was assessed that X would benefit from X to continue to improve and reach X long-term goals (LTGs); X rehab potential and

discharge prognosis were X; X progress towards goals was X; and X tolerance to treatment was X. On X, X, APRN documented a Letter of Medical Necessity for X for low back conditions by X, for X. Per the Program Overview, X presented with chronic lower back pain with a duration of greater than X weeks. X medical history had been reviewed to rule out red flag symptoms that suggested other pathology. Clinical examination revealed weakness of the lumbar extensor muscles and reduced lower back strength and range of motion. X would utilize X to improve weakness and increase range of motion to decrease pain and disability. The program was implemented as part of X. X was also part of the program provided to the patient. Patient monitoring included 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: "Per ODG, X for low back conditions is recommended as a first-line treatment option. It is indicated for chronic lower back pain or during the recovery period after a lumbar spine procedure, which includes that the clinical examination must X. In this case, the claimant is in the chronic phase of injury and reports pain in the left lower extremity. The claimant has already X. Upon discussion, Dr. X reported that the claimant had X. The provider stated that the claimant will have X. However, the current request for a X. Therefore, the request for X is not medically necessary. "An appeal letter dated X for the appeal for authorization of X that was denied on X as "Not Medically Necessary." The letter contained an Introduction and reasons provided as to why the appeal was necessary. Per the Introduction, "This letter constitutes a formal appeal of the non-certification issued for X. The patient is a X individual who sustained a lumbar injury on X. The patient has X. Lumbar extensor muscle weakness has been documented clinically and confirmed through peer-to-peer review. A Letter of Medical Necessity dated X supports the request Reconsideration and certification of the requested X are respectfully requested." Under the heading "The ODG Guidelines Have Changed" it was noted, "The assessment applied the Official Disability Guidelines criteria requiring that X. Those guidelines are no longer in effect Effective X, ODG issued updated criteria for X The current guidelines govern this appeal. The denial cannot be sustained on the basis of superseded guideline language." Under the heading "X" it was noted, "The prior ODG criterion requiring use as part of a X has been removed in its entirety. The current guidelines do not require X. The current criteria explicitly require that the X. This represents a X. To the extent the denial rests on X." Per The Clinical Criteria Were Effectively Conceded: "The assessment acknowledged that the patient is in the chronic phase

of injury, has X. During peer-to-peer review, the treating provider confirmed that the patient had X. The reviewer did not dispute the chronicity of the condition, the documented weakness, or the clinical basis for the request The criteria of chronic low back pain and lumbar extensor muscle weakness were not contested." Per "The X Has No Foundation In ODG: The operative basis for denial is that X. This rationale cannot be sustained. The current ODG guidelines contain no provision limiting the duration of a X. The X is the standard requested duration for the X. A denial premised on a limitation that does not exist in the applicable guidelines is without foundation. Regarding, "The Patient Meets All Current ODG Criteria: The current ODG guidelines recommend X. Each is addressed in turn. Chronic low back pain of greater than X weeks' duration. The patient sustained a lumbar injury on X and continues to experience chronic low back pain as confirmed by multiple clinical encounters through X, a duration exceeding X weeks. The assessment itself acknowledges the patient is in the chronic phase of injury. This criterion is met. Clinical examination reveals X. Weakness and reduced strength of the lumbar extension muscles were documented on X, with a significant extent of decreased range of motion in the back noted. The X Re-Evaluation dated X documented ongoing severe functional impairment and tenderness to palpation at X. The Letter of Medical Necessity dated X confirms weakness of the lumbar extensor muscles as a clinical finding. During peer-to-peer review, the treating provider confirmed ongoing extensor muscle weakness following X, The patient confirmed in a completed patient survey that a healthcare provider communicated that the lumbar muscles are weak or imbalanced, and reports very significant weakness and fatigue in the lower back during daily activities. This criterion is met. X is intended and marketed for X. The X is a X. It is functionally comparable to the X. This criterion is met. Patient is actively participating in a X. The patient has X and remains under active medical management. The Letter of Medical Necessity and Physical Therapy Re-Evaluation both support the need for X. This criterion is met. No red-flag symptoms suggesting need to rule out other pathology. The medical record reflects no X, and no new findings requiring X. This criterion is met." In Conclusion, "The denial of the X. The supervision criterion cited in the assessment has been eliminated. The clinical criteria of X were not disputed and are well supported by the record. The sole operative basis for denial - that the X. All current ODG criteria are satisfied. Certification of the requested X is respectfully requested. "Per a reconsideration / appeal review adverse determination letter dated X, the appeal

request for X was denied by X, DO. Rationale: “ODG indicates that X may be indicated when all of the following are met: X. In this case, in the voicemail, Dr. X stated that the objective findings of weakness in extension is notes on the letter of medical necessity. The provider stated that this is the first time this X and it was requested to help strengthen their extensor muscles. Dr. X stated that the claimant has X. While there is generalized notation of weakness, there is no documented evidence of exam findings with objective strength deficits in the lumbar extensor muscles. There is no evidence of X with specific and sustained benefit Therefore, this request is not medically necessary.”

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

The submitted clinical records indicate that the Official Disability Guidelines have been updated and no longer require X. The current criteria explicitly require that the X. This represents a reversal of the prior standard. The submitted clinical records indicate that this claimant is in the chronic phase of injury. The claimant has X. The patient continues to experience weakness in the lumbar extensor muscles. Given the current clinical data and the substantial change in guidelines, the request is for certified. Based on the clinical information provided, the request for X is recommended as medically necessary and the previous denials are overturned.

Overturned

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)**