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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 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, when X. X reported loss of consciousness and urinary incontinence during the X. The diagnosis was low back strain, contusion of left knee, and contusion of left shoulder. On X, X was evaluated by X, MD. X stated that after X injury, X was X. A CT scan of the cervical spine showed X. There was also note of X. A CT scan of the

chest showed X. There was X. X was discharged on the same day and followed up at an X for the diagnosis of lumbar strain, left shoulder contusion, left knee contusion. X reported ongoing complaints of X pain in the low back radiating to X left leg. On examination, X had an X, difficulty performing heel toe walking and squatting unassisted. There was bilateral lumbar paraspinal muscle spasm and tenderness noted at the X. There was decreased range of motion and pain with movement of the lumbar spine, especially with flexion and extension. Muscle strength was X at the left dorsiflexors and the left plantar flexors. There was decreased ROM and pain with movement of the left shoulder, especially with abduction and flexion; X at the left shoulder; and X muscle strength noted at the X. The assessment was low back strain, contusion of left knee, and contusion of left shoulder. It was noted that X was X. X was started and X and X. X was requested and a X of light stretching and an X recommended. In a Letter of Medical Necessity, dated X, X, MD, noted that X presented to the X and reported low back pain. There was a decreased range of motion and pain with movement of the lumbar spine, especially flexion and extension. Examination of X revealed weakness in the lumbar extensor muscles. X would benefit from the 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 the submitted documentation, the request is not supported. The Official Disability Guidelines recommended a X. There should be documentation that the X. The claimant should be actively participating in X. There should be no red-flag symptoms suggesting need to rule out other pathology. In this case, while it was noted that the claimant had chronic lower back pain, decreased range of motion, and pain with movement, the request cannot be authorized since there was no quantified or objective findings that showed significant weakness of lumbar extensor muscles. Additionally, there was no clear documentation that they were participating in X. Therefore, the prospective request for X is non-certified. ”A letter of appeal for the authorization of X, dated X, was documented by an unknown provider. It was concluded that the adverse determination was not supported by the X. Lumbar extensor weakness was explicitly documented in the provider's letter of medical necessity and was further corroborated by objective examination findings of lumbar paraspinal spasm and pain-limited extension, and the reviewer's requirement for objective or quantifiable weakness findings had no basis in the applicable guidelines. X was actively participating in a X. The X. Each

basis offered for denial was either directly contradicted by the record or had no foundation in the applicable guidelines. Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "The Official Disability Guidelines conditionally recommend X. It is supported when the X X. The prior denial of the requested X on X under review #X was due to the lack of documented objective clinical findings demonstrating X. Although the appeal submission clarified objective findings of lumbar paraspinal muscle spasm and tenderness from X through X, decreased range of motion with pain on lumbar extension, and active participation in a X. The claimant presented with chronic, severe low back pain accompanied by radicular symptoms radiating into the left leg, an antalgic gait, difficulty with heel toe walking and squatting, and documented weakness of the left lower extremity, including decreased strength of the dorsiflexors and plantar flexors. The presence of both weakness and radicular symptoms may indicate underlying neurological concern. In this case, the claimant's persistent X. This criterion was overlooked in the prior determination and was subsequently identified as an important contraindication to the use of the requested X. Despite acknowledgement of chronic low back pain, attempted X, the request is not medically necessary due to the presence of X. Therefore, the appeal request for X is non-certified."

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

The Official Disability Guidelines states that a X may be recommended when all criteria is met including chronic low back pain of at least X weeks' duration; clinical examination findings of weakness of lumbar extensor muscles; documentation that the X X. In this case, the claimant has a history of chronic low back pain. Treatment to date includes X. At the visit on X, the claimant reported ongoing complaints of X pain in the low back radiating to X left leg. Exam findings included antalgic gait, difficulty performing heel toe walking and squatting unassisted, bilateral lumbar paraspinal muscle spasm and tenderness noted at the X, decreased range of motion and pain with movement of the lumbar spine, especially with flexion and extension, and muscle strength graded X at the left dorsiflexors and the left plantar flexors. A letter of medical necessity dated X states there was exam finding of X. Per the appeal letter dated X, provider states X was corroborated by findings of X and pain-limited extension. However, the

claimant has ongoing X. Criteria for use as per guidelines require no red flag symptoms suggesting need to rule out other X. The clinical picture suggests deficits and symptoms are due to underlying X. For these reasons, the request for X is not medically necessary and the decision is upheld.

Upheld

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)**