IRO Express Inc.
An Independent Review Organization
2131 N. Collins, #433409
Arlington, TX 76011
Phone: (682) 238-4976
Fax: (888) 519-5107
Email: @iroexpress.com

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 Overturned Agree in part/Disagree in part

☐ Upheld Agree

IRO Express Inc.

Notice of Independent Review Decision

Case Number: X Date of Notice: X; Amendment X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X, after X. The diagnosis was strain of muscle, fascia, and tendon of lower back, initial encounter.

On X, X presented to X, MD, for chronic low back pain involving the lumbar spine and sacral spine. Symptoms were aggravated by all activities, were constant, radiating to the left leg and sacral spine, sharp, and rated X at the time. X reported difficulty with activities of daily living. X had been X. On examination, both lower extremities revealed X. Thoracic spine range of motion was grossly limited and with pain; flexion and extension were limited and with pain. Lumbar spine range of motion was grossly limited and with pain, flexion and extension were limited and with pain. Left hip range of motion was painful. Left hip special tests showed X. An MRI of the lumbar spine dated X, an MRI of the thoracic spine dated X, and an undated MRI of the cervical spine were reviewed. In a Letter of Medical Necessity dated X, X, MD, provided the medical necessity justification for the prescribed X as follows: “ODG Recommended X that may be a first line treatment option. Patient will X compared patients who strengthened their low back with the X. Patients who X. The X will X. In a letter dated X, X, X, wrote, “X has been prescribed the X by X healthcare provider, Dr. X to address X back condition. During examination, Dr. 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, sharp pain in X lower back, which radiates down X left leg. X experiences difficulty with all activities of daily living, as X pain is aggravated by all activities. Despite undergoing extensive conservative treatment since X injury, X has not seen any positive results. X outlines several reasons

supporting the use of the X: 1. X lower back pain is consistently severe, with a constant rating of X, regardless of whether it is a "good" or "bad" day. 2. X lower back pain limits X capacity to walk continuously for X minutes, manage stairs, and perform errands. 3. X lower back pain sometimes prevents X. Dr. 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 a X."

Per the progress note dated X, an MRI of the lumbar spine dated X, was reviewed and demonstrated moderate facet arthritis at X; bulging disc, mild central canal stenosis, moderate facet arthritis, moderate bilateral foraminal stenosis with foraminal disc protrusion, and possible bilateral X root displacement at X; bulging discs, mild central stenosis, and moderate facet arthritis, and mild foraminal stenosis at X. An MRI of the thoracic spine dated X, revealed X. An undated MRI of the cervical spine revealed moderate right foraminal stenosis at X; bulging disc, small central protrusion, mild central stenosis, and mild right foraminal stenosis at X; bulging disc, mild central stenosis, and mild foraminal stenosis at X; bulging disc at X.

Treatment to date included X.

Per a utilization review / Notice of Adverse Determination letter dated X, the request for X was denied by X, MD. Rationale: "The Official Disability Guidelines recommends X. In this case, the claimant complained of chronic, constant low back pain radiating into the left leg, rated at an X severity and aggravated by all activities. The examination showed grossly limited and painful lumbar range of motion in flexion and extension, along with X. The request does not meet the guideline criteria as there is no evidence of lumbar extensor weakness, and the X. Additionally, the claimant is not successfully participating in a X. The MRI findings of X. A phone call to the office of X, MD, at X was placed on X at X AM CT. This discussion included the claimant's treatment. The claimant has been in treatment

for over X weeks for low back pain, and is currently engaged in X. Per providers report, the claimant displays weakness of the lumbar musculature. At times the X worsens symptoms. Low back pain is the focus of treatment, but records note occasional lower extremity pain, suggesting possible foraminal impingement. The occurrence of LE pain, and the complexity of the requested X is non certified. Therefore, the prospective request for X is non-certified."

An appeal for authorization of X dated X, by an unknown provider, documented in conclusion that the adverse determination was not supported by the X ODG criteria for X. Lumbar extensor weakness was confirmed by multiple independent sources the reviewer's own peer-to-peer call documentation recorded that weakness of the lumbar musculature was confirmed during that exchange, and the patient survey corroborated this finding, documenting that a healthcare provider communicated the presence of low back muscle weakness to the patient, that the patient experienced weakness and fatigue in the lower back during daily activities. and that the patient's pain and functional limitations were consistent with the clinical findings of grossly limited and painful lumbar range of motion in both flexion and extension. The X was a X that did not exceed the complexity threshold established by ODG, and the reviewer's complexity conclusion was not grounded in any specific ODG exclusion criterion. The patient was actively participating in a X as required. No ODG red-flag contraindications were present. 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: "Regarding X, the Official Disability Guidelines conditionally recommend X when all criteria are met. The guideline outlines that X may be indicated when chronic low back pain is present, clinical examination documents weakness of the lumbar extensor muscles, the X is intended for X. Based on submitted documentation, the request is not warranted. In this case, the claimant reported chronic low back pain with radiation into the left leg and difficulty with daily activities. On physical examination dated X,

lumbar range of motion was grossly limited and painful, and left hip testing was X. Neurological testing showed intact sensation and X percent reflexes bilaterally. However, the submitted medical records did not document objective lumbar extensor muscle weakness required by the guideline. Prior X worsened symptoms, which did not demonstrate successful participation in a X. MRI findings dated X demonstrated disc bulging with possible X root displacement and moderate foraminal stenosis, raising concern that X. Although the provider appealed the prior determination and asserted that weakness was confirmed during a peer to peer call, no objective documentation of lumbar extensor weakness was submitted in the medical record. The guidelines were not met, and the request was not medically necessary. No guideline based variance was supported. Therefore, the appeal for the prospective request for X is non-certified."

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

Based on submitted records, the prospective request for X for the period of X - X is certified. Based on the X ODG criteria are met: patient presents with lumbar radiculopathy exceeding X weeks with persistent X pain, limited lumbar range of motion, and documented lumbar extensor weakness, the X does not incorporate any ODG-excluded features, the claimant is actively participating in a prescribed X. The prior non-certifications/denials are not supported, both prior reviewers applied extra-guideline standards not found in the X ODG by requiring objective measurement of weakness beyond what the guideline requires, citing foraminal impingement as a contraindication despite its absence from the applicable ODG red-flag criteria. As such, based on review of the records, the request for X meets the criteria of medical necessity and is therefore the previous denial is overturned.

Overturned

IRO Express Inc.

Notice of Independent Review Decision

Case Number: X

Date of Notice: X; Amendment X

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE