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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 at work on X. The mechanism of injury was not documented. The diagnosis was lumbar sprain / strain

On X, X was re-evaluated by X, MD, with respect to a work-related injury sustained on X. X reported X felt about the same, burning, sharp, throbbing, pins and needles, numb and tingling, X pain, and was unable to work. X wanted to lie down; lying down was X form of relief. Any activity made the pain worse. X reported no new symptoms. X had been following the treatment plan, which did not help. X is on X. X had X. A X had not helped. X had MRIs and other workup in the past. X had an X, which did help significantly, but X continued to complain of right lower back pain. X was pending a X. On musculoskeletal examination, toe and heel walking was poor on the right. Flexion, extension, rotation of the lumbosacral spine was decreased by X to X in all planes. There was X.

An MRI of the lumbar spine dated X, demonstrated X. There was enhancement in the dorsal soft tissues, and along the right lateral aspect of thecal sac extending to the right X foramen, and marginating the traversing right X nerve root and exiting right X nerve root. Correlate for radiculopathic symptoms referable to this level. There was mild bilateral foraminal narrowing at X. Mild spinal canal narrowing was noted at X with mild bilateral foraminal stenosis. Clumping of the left X nerve roots was seen and was to be correlated for radiculopathy symptoms referable to this level. Findings could reflect a component of 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: “Based on the documentation, the claimant reported right lower extremity and low back pain with an initial X improvement and sustained X improvement following a X, with prior treatment including X. Physical examination revealed a X. In this case, per ODG, X are not recommended for the treatment of low back pain or sacroiliac joint pain, and there is no documented diagnostic indication supporting the use of this X. Accordingly, because X are not supported for the reported condition and the medical necessity criteria are not met, the requested X is non-certified.”

Per a reconsideration review adverse determination letter dated X, the appeal

request for X was denied by X, MD Rationale: “X "The Official Disability Guidelines specifically note that X are not recommended for treatment of low back pain or X. There do not appear to be exceptional factors to support the request outside guidelines. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. Therefore, standard appeal request for X. X is non-certified.”

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
After review of all submitted medical records, the requested X is upheld. Per ODG X are not recommended for the treatment of low back pain X and are not considered a first-line option. While the claimant does have documented X. Given the lack of diagnostic confirmation and the absence of exceptional clinical factors warranting deviation from current evidence-based guidelines, medical necessity for the X has not been established and the request is upheld.

Upheld

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