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# Notice of Independent Review Decision

## INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr. X, X, and X. Records are only listed from one party if sent more than one time.

Dr. X: X office notes from X, X MRI report, and X x-ray reports for the X.

X: X referral from X, X MRI, office notes from X X to X , XX , X denial letter, X peer review report X, MD, X letter by X, X surgery orders, X progress notes X , DC, X medication script, PT notes X X to X, X denial letter, and X peer review by X, MD.

X: X letter by X.

A copy of the ODG was not provided by the Carrier or URA for this review.

## PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a X who sustained an industrial injury on X. Injury occurred when X was carrying a X from X. X felt the X pain to X. Past medical and surgical history was negative. Records documented a X MRI impression of near X. There was mild X. The patient attended X sessions of X treatment for X. Treatment included X, X program. The X x-ray report impression documented a normal appearing X. The X MRI impression documented mild X. This appeared to involve

less than X. There were no obvious X. Findings documented a mild to X. The X occupational medicine progress report indicated that X pain was improving after X sessions of X. X was seen for review of X MRI which showed less than a X. X exam documented X, limited and painful X, and X. X X exam was within normal limits. The diagnosis included X. The treatment plan recommended refill of X and X consult for the X. Work status was documented as modified work with no X. The X notes indicated that the patient had completed X visits. It was noted that X reported X had helped X improve X. X felt mild improvement in X, but X was limited by X pain that had not changed. Current functional impairments prevented X from performing X standard activities of daily living and/or work activities. X had been educated in a X program and was returned to the primary treating physician. The X orthopedic consult report cited complaints of persistent X pain, grade X at baseline that increased to grade X with any movement, specifically X activity. X reported that pain woke X up X. X reported X was very difficult and X. X had tried physical therapy and medications, including X, but none of this had helped. X denied any X pain or X. X exam was within normal limits. X exam documented active range of motion as X degrees and X degrees. X documented X degrees with pain. X and X tests were positive. There was X over the X and a positive X test. X had X to resisted X with pain. Review of X MRI showed a X. There was a X and a X with some mild X. The patient had a X. X was having X pain, severe pain with X activity, and X. The treatment plan recommended X. The X peer review report indicated that the request for X was not medically necessary. The rationale stated that guideline criteria had not been met for surgery as X had not completed and failed to respond to a X to X-month course of conservative treatment. A request for reconsideration was submitted on X. The X peer review report indicated that the appeal request

for X was not medically necessary. The rationale indicated that there was no documentation that the patient had exhausted X to X months of conservative treatment, including X, to support the medical necessity of surgery.

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

The Official Disability Guidelines provide specific indications for X that include X to X months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Earlier surgical intervention may be required with failure to progress with therapy, high pain levels, and/or mechanical catching. Criteria additionally include subjective clinical findings of painful active XX of motion X degrees and pain at night, plus weak or absent abduction, tenderness over the X, greater X, or X area, X sign with a positive X test, and imaging showing positive evidence of at least X. Guidelines do not recommend X as an isolated procedure since best-evidence regarding long-term clinical outcomes for surgery has consistently been no better than conservative treatment for X.

This injured worker presents with persistent X pain with weakness. Pain is reported grade X at rest and increases to grade X with activity. Pain and functional limitations interfere with activities of daily living and preclude return to work full duty. Clinical exam findings have documented painful and limited range of motion, pain at night, external rotation and abduction weakness, X tenderness, and positive X signs. There is imaging evidence of a small X. Detailed evidence of X weeks of reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. X has failed to achieve adequate improvement despite X

sessions of X treatment to the X. The prior utilization review determinations have denied surgery as there was no evidence of X to X months of failed conservative treatment. However, guidelines state that earlier surgical intervention may be required with failure to progress with therapy, high pain levels, and/or mechanical catching. Given the patient's high pain levels with activity, significant functional limitations precluding return to work, failure to progress with therapy and ongoing retraction of the torn portions of the X surgery is guideline supported at this time. Therefore, the prospective request for X is medically necessary.

**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**

☐ **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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY 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)**