**Applied Assessments LLC**
**An Independent Review Organization**
**900 Walnut Creek Ste. 100 #277**
**Mansfield, TX 76063**
**Phone: (512) 333-2366**
**Fax: (888) 402-4676**
**Email: admin@appliedassessmentstx.com**

## *Notice of Independent Review Decision*

**IRO REVIEWER REPORT**

**Date:** 1/29/2019 1:14:54 PM CST

**IRO CASE #:** XX

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Decompressive XX XX and XX level XX-XX, XX-XX

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** Orthopaedic Surgery

**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 |

**PATIENT CLINICAL HISTORY [SUMMARY]:** XX. XX XX is a XX-year-old XX who sustained a work-related injury on XX while XX. XX was diagnosed with a XX XX (XX.XX). XX performed an impairment rating evaluation on XX. It was determined that XX. XX had reached a clinical plateau as no intervening change in the condition or reasonable expectation of improvement could be expected after XX. Per an amended summary dated XX, XX had not reached clinical maximum medical improvement (MMI), but was expected to do so on or about XX. XX had elected to proceed with the recommended surgery with XX. The XX-sided XX-XX XX falls within the treatment guidelines of the ODG for the

compensable injury and was expected to improve XX condition. Therefore, XX had not yet reached MMI, but was expected to do so on or about XX, which would allow for approval for the surgery and postoperative physical therapy. On XX, XX. XX was evaluated by XX for XX XX pain. XX stated that the pain had improved a little, but did have pain when standing for long periods. XX also reported XX sided XX pain. The pain located at XX XX area. It was described as severe, radiating, and present for years. On examination of the XX XX, XX was positive on the XX. Range of motion of the XX XX was full and produced XX XX pain. XX XX was normal. The assessment was XX XX. XX opined that XX. XX remained symptomatic from XX XX and XX, and failed conservative care including several injections. The plan was to proceed with XX-sided XX XX and XX at XX-XX with XX on the XX at XX-XX. An XX of the XX XX dated XX revealed mild degenerative changes at XX-XX and XX-XX. There was a XX XX XX at the XX-XX level. At the XX-XX level, there was XX XX XX protrusion, XX XX, and XX XX thickening causing mild XX narrowing of the XX. At the XX-XX level, there was XX XX XX protrusion causing mild XX of the XX XX recess and potential contact with the traversing XX XX XX root. XX XX XX was noted. The treatment to date included medications (XX, XX, XX, XX, XX, and XX), physical therapy, XX therapy, home exercise program, and XX XX-XX XX XX (provided temporary relief) on XX and XX.

Per a utilization review decision letter dated XX, XX denied the request for decompressive XX XX and XX at the level XX-XX and XX-XX. Rationale: “A peer to peer was not successful. In regards to the request for decompressive XX XX and XX level XX-XX and XX-XX, the Official Disability Guidelines state XX / XX is recommended with positive symptoms and imaging studies and trial and failure of conservative measures. An XX of the XX XX dated XX reveals mild XX changes at XX-XX and XX-XX. Physical examination of the XX XX dated XX reveals positive XX on the XX. There is no documentation of physical findings, imaging findings or exhaustion of all conservative measures to warrant the request. As such, the request for decompressive XX XX and XX level XX-XX and XX-XX is non-certified. Because an adverse determination for surgery has been rendered, an adverse determination for any associated pre-operative clearance is also rendered. Conversations between the requesting provider and the reviewing physician, if any, may provide additional information for the reviewing physician to consider; however, a lack of a successful peer-to-peer conversation does not result in an automatic adverse determination. Utilization review decisions are based on evidence-based guidelines and the medical documentation submitted for review.”

Per a utilization review decision letter dated XX, XX reviewed the appeal of the utilization review denial determination which was received on XX. It was determined that the requested service of decompressive XX and XX level XX-XX and XX-XX still did not meet the medical necessity guidelines. Rationale: “The requested surgery was denied on initial review on XX due to lack of documentation of physical findings, imaging findings, or exhaustion of all conservative measures to warrant the request. Regarding decompressive XX XX and XX level XX-XX, XX-XX, ODG notes that surgical decompression of a XX XX root or roots may include the following procedures: XX or XX (XX of the XX) and XX, XX, XX, or XX (providing access by partial or total removal of various parts of XX). XX is the surgical removal of XX material that presses on a XX root or the XX. A XX is often involved to permit access to the XX in a traditional XX. XX/XX is recommended for patients with XX confirmed by clinical and diagnostic testing and evidence of failed conservative care. Objective findings on examination need to be present. XX test, crossed XX, and reflex exams should correlate with the symptoms and imaging. A peer-to-peer was established with XX. Upon discussion, the provider states that the claimant has a XX that is clearly compressing the XX XX XX at the XX-XX level, and some degeneration that is causing slight XX XX at the XX-XX level on the XX. XX states that physical examination shows only XX XX testing while the strength and sensation are preserved. However, per the provider, the pain pattern is very specific, running from the XX XX down the XX in the XX-XX pattern. Additionally, three XX to the XX side at XX-XX and XX-XX were diagnostically positive, and the claimant has failed physical therapy, XX, medications, and home exercise. The medical records note that the claimant complains of XX XX pain and XX-sided XX pain. Treatments have included physical therapy (PT) / XX care and injections. XX test is positive on the XX. The XX shows that XX-XX has XX XX XX XX, XX, and XX thickening, but no XX narrowing and XX compromise. XX-XX has a XX XX XX XX and XX causing mild narrowing of the XX XX and potential contact with the

traversing XX XX XX root. Discussion noted that the XX showed a XX clearly compressing the XX XX XX at XX-XX and some XX that is causing slight XX XX at XX-XX on the XX. Discussion confirmed the positive XX test on the XX, and intact sensory and motor functions, but the provider noted that the pain pattern is very specific, running from the XX XX down the XX in the XX-XX pattern. Discussion noted that three XX injections to the XX side at XX-XX and XX-XX were diagnostically positive, and the claimant has failed physical therapy, XX, medications, and home exercise. However, the clinical records provided for review do not reflect some of the information provided during the discussion. The documentation does not provide a description of a XX pattern of pain to support correlation with XX-XX, XX-XX pathology. There is also no description of the pattern of reproduction of symptoms upon XX maneuver, which is required by the guidelines. The XX (XX) were considered diagnostic per case discussion, but XX were injected, and it is not established if only XX injection would have resulted in a better definition of the pain generator. Therefore, the medical necessity of decompressive XX XX and XX level XX-XX, XX-XX is not established. Recommended non-certification for decompressive XX XX and XX level XX-XX, XX-XX. Because an adverse determination for surgery has been rendered, an adverse determination for any associated pre-operative clearance is also rendered."

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

In review of the provided records, the claimant has a history of XX XX and XX XX pain that had persisted despite physical therapy, medications, and XX injections. XX studies did note possible contact of the XX XX XX root at XX-XX. There was some XX narrowing present at XX-XX; however, there was no evidence of XX root involvement. The records did not demonstrate that XX testing reproduced particular XX symptoms. There was no evidence of correlating physical exam findings such as motor weakness, loss of sensation, or reflex changes. Other diagnostic testing to confirm a multi-level XX was not submitted for review. These issues which do not meet guideline recommendations, it is this reviewer's opinion that medical necessity cannot be established and the prior denials are upheld.

Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

# Applied Assessments LLC

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**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 XX PAIN

☐ INTERQUAL CRITERIA

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

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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

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

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

ODG Indications for Surgery™ -- XX/XX --