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IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX at XX-XX with possible XX and XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This case was reviewed by a Board Certified Doctor of Orthopedic Surgery with over 18 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on XX on the job as a XX and XX.

XX: Progress Note by XX
XX: MRI of the XX XX without contrast interpreted by XX. **Impression:** XX XX XX with moderate XX recess XX at XX-XX and XX XX at XX-XX and XX-XX with compression of XX and XX XX as above straightening of the normal XX likely a reflection of XX XX.

XX: Office Visit by XX. **HPI:** Patient has been experiencing XX XX pain that radiates to XX XX XX. Patient states that XX pain is the result of a work related injury that occurred on XX that has already been documented. XX states that XX has been experiencing weakness and numbness to XX XX XX. Patient has already had PT and has been on anti-inflammatory pain medication without significant significant improvement in XX pain. Pain has been affecting XX. Onset XX. **Assessment:** 1. XX XX pain. 2. XX XX. 3. XX XX. 4. XX XX XX. 5. XX XX dysfunction. 6. XX XX XX w/o XX. 7. XX 8. Other XX, XX region. 9. Other XX, XX region. 10. Other XX, XX region. 11. XX XX, XX region without XX XX. **Treatment:** Continue with current pain meds.

XX: Office Visit by XX. **HPI:** Patient states XX drastically helped with pain, however, recently XX has been experiencing increased, localized, XX sided XX XX pain. **Treatment:** Continue current meds. Order XX XX XX XX XX,

XX XX, XX, XX.

XX: Office Visit by XX. **HPI:** Patient experienced significant decrease to XX XX pain radiating to XX XX XX. Patient is pleased with results of XX XX XX, XX, XX, XX on XX.

XX: Office Visit by XX. **HPI:** Patient experienced 100% pain relief from XX. But pain has gradually been coming back, so XX wishes to continue this form of treatment.

XX: Office Visit by XX. Patient has not responded to XX PT sessions or XX injections. I will recommend XX XX of XX, XX, XX.

XX: Adverse Determination performed by XX. **Rationale for Denial:** XX. Consequently, the request is not supported. As such, the request is non-certified.

XX: UR performed by XX. **Rationale for Denial:** Based on the clinical history, exam and imaging findings, the requested surgical request is denied at this time. ODG/Treatment Guidelines are not met. A specific XX was not delineated either in a subjective or objective fashion. No pain management documentation was provided. The patient's pain generators were not clearly delineated. There was no XX documentation of XX and extension x-rays of the XX XX in order to assess stability. The most recent note provided by XX commented that the patient had a XX in association with a XX at XX-XX. The MRI report made no comment as related to a XX. Again, a XX XX series. XX views, was not documented. No electro diagnostic studies were performed in order to objectify a specific XX. In conclusion, in the setting of poor documentation, poor delineation of the patient's pain generators and incomplete assessment of stability, the requested surgical services are denied.

XX: XR XX XX complete XX/XX/XX interpreted by XX. **Impression:** XX view obtained demonstrates mild XX. Acute fracture or XX is not present. XX or XX is not appreciated. XX XX disease changes and XX XX is seen in the XX XX especially from XX down to XX. With XX and XX there is no evidence of XX. XX XX or XX XX is not seen.

XX: Office Visit by XX. Based on the clinical history, physical and imaging findings I have requested a surgery to be considered. According to guidelines the patient has been exposed to conservative treatment and this has not helped with XX symptoms. Following the recommendations by the doctor who has reviewed this case. I have sent the patient for an x-ray of XX and XX. I have sent XX for psychological evaluation. Also, I am enclosing with this letter XX records and proof of XX pain management treatment and physical therapy. The surgery that I am recommending for this patient is a XX XX with XX of levels XX-XX-XX with probable XX and XX. I am requesting the XX due to the XX of the XX. In my medical opinion that will give the patient instability, but if the UR agent believes XX does not need the XX, I am willing to change the surgery to a XX XX and XX of XX-XX-XX.

XX: UR performed by XX. **Rationale for Denial:** This is a non-certification of an appeal of a XX XX at XX-XX with possible XX and XX. The previous non-certification on XX, was due to lack of specific physical examination findings, lack of appropriate imaging, and lack of exhaustion of XX XX of care. The previous non-certification is supported. Additional records included an appeal on XX, which indicated there had been XX XX of care. The XX and XX x-rays reported no evidence of XX XX instability as required for XX. There was no electro diagnostic study reporting XX. The records do not reflect XX XX of care including a home exercise program or use of neuropathic medications. The case was discussed with XX. Although the claimant has had some sensory changes, the claimant has not had any motor strength changes. An XX was done, but did not show any XX.

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

The request for XX XX at XX-XX with possible XX and XX is not medically necessary, and is denied.

The patient is a XX year-old XX who injured XX XX in XX. XX continues to have pain in the XX XX with radiation to XX XX XX. The XX XX MRI study of XX identified XX XX at XX-XX and XX-XX with moderate XX XX at XX levels. Grade I XX was identified at XX-XX. The patient has completed XX sessions of physical therapy and XX XX XX injections. XX-XX radiographs of the XX XX (XX) did not identify any instability or XX. The treating physician has recommended XX XX XX-XX and possible instrumented XX.

The diagnosis of XX XX associated with pathology at either XX-XX or XX-XX is not clearly defined in the medical record. The physical examination that is documented does not mention specific XX or muscle groups affected by XX at either of these levels. Furthermore, there is no documentation of XX (XX-XX).

The XX-XX views of the XX XX demonstrate no evidence of instability or XX to justify instrumented XX at these levels.

The records reviewed do not support the recommended surgery.

Per ODG:

Recommended for XX XX XX.

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**
- ☐ **AHCPR- 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**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME**

FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)