Independent Resolutions Inc.

Notice of Independent Review Decision

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records –X
• Presurgical Psychological Evaluation Summary –X
• Designated Doctors Examination - - X
• Letters –X
• Utilization Reviews –X
• Peer Reviews –X
• EMG and Nerve Conduction Study Report –X
• Diagnostic Data Reports –X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X with a date of injury X. X was injured when a XX X approximately X feet. The XX X and hit the XX of X X XX. X was diagnosed with X producing severe X. On X, X was evaluated by Dr. X for injury to X X. When X was injured, X X had X pain. X took X week off and then returned to work but could not do it secondary to pain. X had undergone X as well as X. X continued to have constant X pain with X pain. The X pain was worse than the X. X also complained of constant X. The X pain appeared to be X. The pain was rated as X. The pain aggravated by X. X had preoperative clearance for a X completed by X, XX on X, and was considered to be an excellent candidate for the X procedure. Due to X failure to improve with conservative treatment, X would like to proceed with the X. The pain was affecting X quality of life as X was unable to X at a time. the X caused X to XX frequently. The examination showed tenderness to palpation

at the X. X walked with an X. The range of motion of the X revealed flexion X degrees, extension 0 degrees, and X degrees, producing X. X was positive on the XX at X degrees producing X pain. Motor examination was essentially X to all the major X of the X with the exception of X, which seemed to be a new finding. An MRI of the X dated X revealed X extending into both X. Post-X dated X revealed X secondary to X. At X, there was a X. X had a Designated Doctor Examination on X with X, X, MD who made a formal judgement that X had a compensable injury that included X. The X were consistent with X injury. X had distinct signs on examination of sensory X /X, which required a X evaluation. X had not reached maximum medical improvement. An electromyography / nerve conduction study (EMG / NCS) of the X dated X showed no evidence of an X. Treatment to date included X, X, X, and X (helped temporarily). Per a utilization review determination letter dated X by X, MD, the request for purchase of X; X; and one posterior X guidance was not certified. Per evidence-based guidelines, X was indicated after the provision of conservative care in conditions with pertinent subjective complaints and objective findings corroborated by imaging studies. X presented with a X pain with a positive X test bilaterally. However, there was limited objective evidence of X and X of other non-operative measures prior to considering the requested surgery. The guideline stated that all X were completed with documentation of reasonable patient participation with rehabilitation efforts including X visits, and performance of X program during and after X, which could not be fully established in the medical records submitted. As the requested surgery was not supported, that X request for X not supported. Per an addendum note, Dr. X had spoken with Dr. X, who stated that X required a X due to X with other surgeries. X had X, per the provider, which would indicate the need for a X. Dr. X insisted there be a X. After the discussion, it was unclear the need for the X given the imaging findings, therefore, the request was not supported. Per an appeal letter by X, MD dated XX, X had injured X X and X and had pain. X had an extensive X therapy including various X and X therapy. An MRI scan of the X dated X revealed X extended to both X. Post X dated X revealed X. On physical examination, X had evidence of X. As X had not improved with conservative care, the surgery was recommended. The case was discussed with Dr. X and explained

X the reason that X would require X, as well as to remove X protruding X. A X therefore would be needed as X would be unstable, which was described by Official Disability Guidelines as surgically-induced instability. Also, X was having X and X pain and X required a X, which would render X unstable without a X. The utilization reviews dated X by X, DO indicated that the reconsideration request was denied. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request is non-certified. Per evidence-based guidelines, X is indicated after the provision of X in conditions with pertinent subjective complaints and objective findings corroborated by imaging studies. In this case, the patient presented with X pain with a X test bilaterally. However, the recent EMG and NCS findings revealed no evidence of an active X. Also, it was indicated on the guideline that all X and X therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts including X visits, and performance of X X program during and after X, which still cannot be fully established in the medical records submitted. Psychosocial screening should also be submitted to determine the presence and / or absence of identified psychological barriers that would likely hinder post-surgical recovery. As the requested surgery is not supported, that X request for an inpatient stay for X days of inpatient hospital stay and X purchase of X are still not supported."

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

The claimant has been followed for chronic XX XX pain. There is no electrodiagnostic evidence of radiculopathy. The records provided for review did not include any imaging studies of the XX XX noting pathology that would support proceeding with a XX fusion at XX. The records also did not document prior non-operative treatment such as injections or physical therapy. There are no physical therapy reports provided for review demonstrating that the claimant has failed to progress or reached a plateau with formal treatment. Therefore, it is this

reviewer's opinion that medical necessity for the request is not established and the prior denials are X. As the surgical request is not indicated, there is also no requirement for an inpatient stay or post-operative use of a X.
Given the documentation available, the requested service(s) is considered not medically necessary and X.

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

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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES