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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

Date: X: Amendment 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 on X. X was X. The diagnosis included recurrent lumbar radiculitis, lumbar spinal stenosis with neurogenic claudication at X, lumbar spondylolisthesis at X, recurrent lumbar disc herniation at X and lumbar mechanical / discogenic pain syndrome at X. X was seen by X, MD on X for follow up with no significant improvement in X previous symptomatology which included low back pain that X continued to describe as a burning pain with radiation into bilateral lower extremities, right side greater than left, along the lateral thigh and calf, and intermittently into the dorsum of the right foot with associated numbness and tingling in a similar distribution. X was status post a previous anterior lumbar interbody fusion at X with posterior lumbar decompression, posterolateral fusion and pedicle fixation at X performed on X, with subsequent removal of painful hardware at X on X, at X. X continued to describe X discomfort level as a X with worsening symptomatology after prolonged sitting, standing, coughing, sneezing or Valsalva maneuver. X also continued to deny bowel or bladder dysfunctions at the time. Examination showed blood pressure was 141/100 mmHg, weight 215 pounds and body mass index 29.2 kg/m2. Lumbar range of motion was restricted in forward flexion secondary to pain. Motor exam revealed X strength in tibialis anterior and extensor hallucis longus muscle on the right, otherwise X throughout. X was antalgic. X had marked difficulty with heel walking and less difficulty with toe walking. Tandem walk was constrained secondary to pain. Straight leg raising was positive bilaterally at X degrees. Spurling's sign was not tested. Sensory exam revealed a X. Coordination was intact in finger to nose exam and rapid alternating movements. Anterior abdominal and posterior lumbar incisions were well healed. Surgical intervention was recommended at the time due to failure of conservative medical therapy with evidence of surgically induced mechanical intervertebral collapse with advanced degenerative changes after surgical decompression. Transforaminal

lumbar interbody fusion at X with posterior lumbar decompression to include bilateral facetectomies thus predisposing X to iatrogenic instability and posterolateral fusion at L4 and L5 with pedicle fixation at L4 and L5 was recommended X-rays of the lumbar spine dated X demonstrated age indeterminate, mild compression deformity seen at T12 with up to 20% height loss. Mild degenerative disc disease most prominently seen at L4-L5 was noted. A computerized tomography (CT) lumbar spine post myelogram with intrathecal contrast dated X revealed X. There was no spinal canal stenosis. Mild right greater than left neuroforaminal stenosis was noted. Mild bilateral subarticular recess stenosis was noted. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The CT myelogram only demonstrates mile spinal stenosis. In addition, there is no indication of spinal instability at the L4-5 segment.” The request for X was also denied. Rationale: “As the X is not supported, this associated request for X is not medically necessary”. The request for X Dr. X was also denied. Rationale: “As the X is not supported, this associated request for X Dr. X is not medically necessary. Dr. X wrote an appeal letter on X stating, “Please accept this letter as an appeal request to X UR review denial to cover the X. The patient now is seen with exacerbation of symptomatology including low back pain that X currently describes as a deep stabbing burning pain with radiation into bilateral lower extremities, right side greater than left, along the lateral thigh and calf, and intermittently into the dorsum of the right foot with associated numbness and tingling in a similar distribution. X continues to describe X discomfort level as an X on a visual analog scale with worsening symptomatology after prolonged sitting, standing, coughing, sneezing or Valsalva maneuver. The patient also continues to deny bowel or bladder dysfunctions at this time. X does describe marked limitation in X ambulation to approximately less than one block without having to "stop for my pain," and is currently ambulating in an arthropod position. X also describes limitation in X standing ability to approximately 5 minutes, again "having to change position for my pain," and continues to describe limitation in X activities of daily living including climbing stairs, driving doing laundry, cooking, etc. Radiographic examination: I reviewed a CT myelogram of the lumbar spine dated X, which demonstrates X. At L4-5 there was disc herniation paracentrally and toward the right with right side greater than left foraminal stenosis, lateral recess stenosis and subarticular stenosis. Disc herniation was approximately X

mm. There was a slight decreased disc height and disc desiccation with retrolisthesis of X approximately X mm contributing to subarticular stenosis and central canal stenosis down to an AP diameter of X mm. Depending on your approval, the X will take place on X. Please do not hesitate to contact me at X if you require any additional information. I really anticipate hearing from you on this subject. “Per a reconsideration review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: “Without radiographic evidence of instability, surgical instrumentation and fusion are not supported by the guidelines.” The request for X was also denied. Rationale: “As the X is not supported, this associated request for X is not medically necessary”. The request for X Dr. X was also denied. Rationale: “As the X is not supported, this associated request for X Dr. X is not medically necessary.” The claimant had been followed for a history of lower back and leg pain status post X decompression and posterior fusion performed in X followed by removal of hardware in X. Lumbar radiographs from X of X detailed mild degenerative spondylosis at X. The X CT myelogram study noted disc bulging with mild stenosis present at the neuroforamina and the subarticular recesses. No spondylolisthesis was evident. The claimant had attended X. The claimant had continued to use X without relief. The records did not include a recent neurosurgical evaluation of the claimant. The last evaluation was from X and is more than X months old. As imaging only detailed minimal pathology at X without evidence of instability, guideline recommendations for X have not been reasonably met. As such, it is this reviewer’s opinion that medical necessity is not established for the X requests and the prior denials are upheld. X is not medically necessary and non certified

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

Per a reconsideration review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: “Without radiographic evidence of instability, X are not supported by the guidelines.” The request for X was also denied. Rationale: “As the X is not supported, this associated request for X is not medically necessary”. The request for X was also denied. Rationale: “As the X is not supported, this associated request for X is not medically necessary.” The claimant had been followed for a history of lower back and leg pain status post

L5-S1 decompression and posterior fusion performed in X followed by removal of hardware in X. Lumbar radiographs from X detailed mild degenerative spondylosis at L4-5. The X CT myelogram study noted disc bulging with mild stenosis present at the neuroforamina and the subarticular recesses. No spondylolisthesis was evident. The claimant had attended X. The claimant had continued to use X. The records did not include a recent neurosurgical evaluation of the claimant. The last evaluation was from X and is more than X months old. As imaging only detailed minimal pathology at L4-5 without evidence of instability, guideline recommendations for X have not been reasonably met. As such, it is this reviewer's opinion that medical necessity is not established for the X requests and the prior denials are upheld. X is not medically necessary and non certified
Upheld

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 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

☐ TMF SCREENING CRITERIA MANUAL