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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: 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 Overtuned 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 working on X. The diagnosis was lumbar intervertebral disc disorder with radiculopathy at X; lumbar disc prolapse with radiculopathy, wedge compression fracture of first lumbar vertebra, wedge compression fracture of second lumbar vertebra, low back strain, and lumbar sprain. X was seen by X, DO, on X for a follow-up visit. X was pending control of diabetes to proceed with surgery. The last labs drawn on X, X was greater than X and glucose was X. X was seen by internal medicine (IM) doctor and would be starting insulin soon. The fasting glucose level that morning was X. The low back pain (LBP) seemed to be increasing with radiation to lower extremities (LE's), left greater than right and weakness to left LE. An electromyography (EMG) report dated X revealed X. On examination, X blood pressure was 133/90 mmHg, weight was 193 pounds and BMI was 29.34 kg/m2. The physical examination revealed X. There was tenderness to palpation at lower left paraspinal muscles of lumbar spine. Sensory examination revealed decreased X. There were functional deficits present while X. Braggard's test was X. Cross leg lift test was X. There was difficulty with heel and toe walk due to pain and lower extremity weakness. Regarding maximum medical impairment, X had not reached at that time. The work status included light duty. X was advised to follow-up with Dr. X and with Dr. X for pending control of diabetes to proceed with surgery. On X, X, MD evaluated X for X week follow-up of back pain. X complained of left greater than right leg pain. The pain was located in the back of the leg. The severity of pain was rated X. X had numbness and tingling in the left leg. X had difficulty with balance. Treatments included X. On examination, X weight was 187 pounds and body mass index (BMI) was 28.43 kg/m2. Motor strength was 4/5 in bilateral deltoids, right iliopsoas, left quadriceps, and left hamstrings, and 3/5 in left iliopsoas and bilateral extensor hallucis longus / tibialis anterior. Sensation was decreased in left L5, left S1, and left L4 distribution. X was antalgic. X had tried all conservative treatment without relief. X had weakness and numbness on examination. X would benefit from a X. X would like to proceed with operation. An MRI of lumbar spine dated X showed X. An anterior compression deformity of L2 with approximately 25% anterior height loss. At L2-L3 level, there was mild anterior endplate spurring with circumferential disc bulge and right foraminal disc herniation measuring 3 mm AP with associated annular tear seen. The central

canal was slightly narrowed and measured X mm in AP diameter. There was ligamentum flavum hypertrophy and mild-to-moderate bilateral facet irregularity and hypertrophy. There was moderate bilateral right greater than left subarticular neural foraminal narrowing with possible impingement of exiting right X nerve root seen. At X level, there was bulky anterior endplate spurring with diffuse endplate irregularity seen. There was diffuse disc herniation and annular tear with the posterior herniated disc measuring 5 mm AP. There was ligamentum flavum hypertrophy and moderate bilateral meet irregularity and hypertrophy seen. The central canal was severely narrowed and measured X mm in AP diameter. There was impingement of intracanalicular descending nerve roots. There was moderate right and severe left neural foraminal narrowing with impingement of exiting left and possible exiting right X nerve roots present. At X level, there was mild anterior endplate spurring with circumferential disc bulge and posterior broad-based disc herniation measuring X mm AP with associated annular tear and impingement of the bilateral intracanalicular descending nerve roots seen. There was a X mm right foraminal lateral recess disc protrusion seen. The central canal was mild-to-moderately narrowed and measured 8 mm in AP diameter. There was moderate-to-severe bilateral neural foraminal narrowing with impingement of bilateral exiting X nerve roots present. At X level, there was minimal anterior end plate spurring present. There was circumferential disc bulge with the posterior broad-based disc bulge / disc herniation measuring X mm AP with associated annular tear and possibly impinging on the descending left X nerve root seen. There was no canal stenosis. There is moderate bilateral facet hypertrophy and irregularity present. There was moderate bilateral neural foraminal narrowing, left greater than right, with impingement of the exiting left and possibly exiting right X nerve roots seen. 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 claimant had continued with ongoing lower back and left leg pain. The claimant had been treated with X. No physical therapy or procedure records were included for review detailing failure of non-operative measures to date. A pre-operative psychological evaluation of the claimant was not included for review ruling out any confounding issues that could impact post-operative outcomes as recommended by current evidence-based guidelines. The current lumbar imaging detailed spondylosis at multiple levels but no evidence of significant spondylolisthesis or motion segment instability. The current evidence-based guidelines do not recommend X. Given these issues which do not meet

guideline recommendations, this reviewer cannot recommend certification for the X requests. As the X requests are not indicated, there would be no requirement for X." On X, Dr. X provided an appeal letter for the denial of X. Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: "The requested X procedure is not medically necessary. The submitted medical records do not indicate the presence of instability. An EMG report does demonstrate X. However, the guidelines have not been met due to the lack of instability present in the lumbar spine. Therefore, the requested appeal for X is not medically necessary. "In review of the clinical findings, the claimant had been followed for ongoing chronic lower back and leg pain with imaging detailing spondylosis and degenerative changes in the lumbar spine which contributed to stenosis of varying severity from L2 to S1. The claimant had not improved with prior physical therapy, medications, or an epidural steroid injection. The claimant did obtain a psychological evaluation ruling out any contraindications for surgery. However, the available imaging reports did not detail evidence of any significant spondylolisthesis or evidence of motion segment instability in the lumbar spine. The current evidence-based guidelines do not recommend X to address lumbar stenosis or degenerative disc disease only. Therefore, it is this reviewer's opinion that medical necessity for the requests has not been established 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:

In review of the clinical findings, the claimant had been followed for ongoing chronic lower back and leg pain with imaging detailing spondylosis and degenerative changes in the lumbar spine which contributed to stenosis of varying severity from X. The claimant had not improved with X. The claimant did obtain a psychological evaluation ruling out any contraindications for surgery. However, the available imaging reports did not detail evidence of any significant spondylolisthesis or evidence of motion segment instability in the lumbar spine. The current evidence-based guidelines do not recommend X. Therefore, it is this reviewer's opinion that medical necessity for the requests has not been established 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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY 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)**