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Notice of Independent Review Decision

Rereview X

Amendment X

IRO REVIEWER REPORT

Date: X; Rereview 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 is a X. X was at the X. X was X. The diagnosis was post laminectomy syndrome, lumbar radicular syndrome, L3-L4 lateral listhesis and instability, and previous L3-L4 decompression. On X, X, MD evaluated X for chief complaint of low back pain and left leg pain. X had X since work injury in X. X pain had recurred. It was discussed with X about the potential treatments which could include X. X pain level was X in neck, arm, mid back, leg, and low back. On examination, X weight was 255.6 pounds and weight was 35.78 kg/m2. X strength was X in bilateral lower extremities. X reproduced radicular pain with lumbar spine extension which appeared to be close down the foramen X on the left. X had good X. X X was stable. X had X. The plan was to proceed with X. X was a possible candidate for X. Given the location of the pain and the asymmetry noted on the MRI scan with postsurgical changes, the plan was to try to X. On X, X, PA-C evaluated X for a follow-up of X, low back pain, and left leg pain. On X, X had received a left X. X had X relief of X symptoms for X week until X symptoms returned back to baseline. At the time of visit, X continued to have back pain with left lower extremity radiculopathy following X. X did feel ready to proceed with surgery at the time after X. X job dramatically affected by X pain since X was a X making X unable to perform X duties. X low back pain was rated X. On examination, X blood pressure was 165/107 mmHg, weight was 248.2 pounds and body mass index (BMI) was 34.74 kg/m2. X strength was X in bilateral lower extremities. X reproduced radicular pain with lumbar spine extension which appeared to be close down the foramen X on the left. X had good X. X X was stable. X had X. X-rays of the lumbar spine exhibited at X, there was X. There was X. A lumbar spine MRI was reviewed. X was a candidate for X per Dr. X recommendation. X had X.

This did help confirm that X. Given the location of the pain and the asymmetry noted on MRI scan with postsurgical changes, the plan was to confine X.An MRI of lumbar spine dated X revealed X. There were X. The last well formed X. Prior X. There were X. X was otherwise within X. X terminated at the X. At X, there was X. There was moderate left and mild right X. At X, there was X. There was possible contact of the descending right X. At X. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per ODG X. Patient Selection Criteria for X. Spinal instability criteria include X." Per the peer-reviewed literature, "X. X." Per ODG X. Per ODG X. There is inadequate objective clinical evidence to support the use of X. "In this case, the requested X is not medically necessary. The medical records demonstrate that the patient has X. The records X. The surgical request does not include performing a X. As such, the guidelines have not been met. Therefore, the request is not medically necessary and is non-authorized. “Per a reconsideration / utilization review adverse determination letter dated X, by X, MD, the request for X as not medically necessary. Rationale: “Official Disability Guidelines recommend X. On X, the claimant presented with low back pain and left leg pain. X is status post X on X with X. X continues to have back pain with left lower extremity radiculopathy following the X. X does X. Lumbar spine examination showed X. X reproduces radicular pain with lumbar spine extension which appears to close down the X on the left. X-rays showed X. Lumbar MRI showed X. X is cleared for surgery. Psychological prognosis for pain reduction and functional improvement is good. A prior review dated X non-certified the request for X due to the medical records demonstrate that the patient has only X. Based on the claimant's imaging report and clinical findings, X does not meet the guideline's indications for the requested X. There is no evidence of X. Additionally, there is no objectively demonstrable instability documented in the physical examination. Per peer-to-peer discussion, the patient has had a X. No

current X. Thus, unable to approve the case. As such, the medical necessity has not been established for the Reconsideration Request for X. In review of the claimant's imaging, there was X. The current evidence-based guidelines X. Further, the records X. As such, it is this reviewer's opinion that medical necessity for the claimant 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 claimant's imaging, there was X. The current evidence based guidelines X. Further, the records did not include a X. As such, it is this reviewer's opinion that medical necessity for the claimant 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

☐ 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