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Notice of Independent Review Decision

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)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]:X.

On X, X was seen by X, MD for initial visit for X. X had been having symptoms since X after X. The pain was described as burning and shooting down the posterior aspect of the bilateral lower extremity (BLE). Associated symptoms included weakness in X BLE. X had treatment for this in the past including X. In addition, X presented with thoracic pain and bilateral cervical radiculopathy. X went to X for X injury on X, received imaging, and was diagnosed with a T12 compression fracture and L1-L4 transverse process fractures of the spine. Examination revealed X. Decreased X was seen. The X was noted. A CT scan of the cervical, thoracic, and lumbar spine were evaluated and showed X. X had a X. X not had back pain in the past, but did since X fall, indicating that X X. X also had X. They discussed that for the compression fracture, a X would be a good option to help relieve X pain as well as prevent further X. An MRI of the lumbar spine was advised.

On X, X was seen by Dr. X for follow-up of continued back pain. X presented to review X lumbar MRI which showed X. X continued to have mid back pain in the area of X. Examination revealed X. The treatment plan was to proceed with X.

On X, X was seen by Dr. X for a follow-up of X. X continued to have severe back pain that X stated was worsening. The pain had been preventing X from doing daily activities, ambulating, or working. X had been taking pain medicines nearly around-the-clock due to the pain, which had been unbearable for X. Despite this, X was denied by insurance on the grounds that it was only indicated for X. Physical examination was unchanged. Lumbar spine x-rays were obtained and reviewed revealing that the X. X had worsening pain from a X. X continued to have tenderness in the area

of the compression fracture. X had an MRI demonstrating that this was an X. It measured at approximately X mm anteriorly and X mm posteriorly which equates to X at that time despite an incorrect reading by the interpreting radiologist of being X height loss. At the time, it measured X mm anteriorly and proximal X mm posteriorly, equating to an over X height loss, which had worsened as was predicted at prior visit. Worsening X would put X at risk for worsening sagittal balance or further compression which may lead to the need for X. The requested X was denied and was explained to only be approved for X. X continued to need X to be able to return to X activities of daily living and to work. X would be scheduled for X.

An MRI of the lumbar spine dated X revealed X. This was consistent with an X. There was an approximately X height loss at this time. The lumbar vertebral bodies showed X. There was X. Small to X were seen throughout the lumbar spine. X was present at 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: “Regarding the request for X. This procedure is not recommended for X. The guideline indicated that X. The Official Disability Guideline does not contain recommendations for X. Proceeding with the request for X. Medicals showed that the claimant suffered a X X. MRI showed evidence of X. Considering that the claimant has a X, this request would not be warranted, as the guideline only supports this procedure for X. Furthermore, when requested for guideline-supported conditions, the guidelines require a X. Therefore, the prospective request for X is non-certified.”

On X, Dr. X placed an appeal request against the denial for X.

Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Regarding the request for X. This procedure is not recommended for X. X require a lack of satisfactory improvement with medical treatment. The Official Disability Guideline does not contain recommendations for fluoroscopy guidance; therefore, an alternative source of evidence was consulted. According to X. It appears that the previous non-certification was warranted. The claimant suffered an X. The treatment to date has included X. The prior non-certification was based on the fact that the cited guidelines do not support X. Therefore, the appeal request for X is non-certified.”

The claimant presents with imaging evidence of a X. The current evidence based guidelines do not recommend X. No other exceptional factors were detailed that would support proceeding with the X. Therefore, it is this reviewer’s opinion that medical necessity is not 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:

The claimant presents with imaging evidence of a X. The current evidence based guidelines do not recommend X. No other exceptional factors were detailed that would support proceeding with the X. Therefore, it is this reviewer’s opinion that medical necessity is not established and the prior denials are upheld. X is not medically necessary and non certified.

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)**