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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 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 involved in a X. The diagnosis was cauda equina syndrome and traumatic epidural spinal hematoma and arachnoiditis at X. Per a Post Designated Doctor's Required Medical Examination report dated X by X, MD, the purpose of evaluation was to address maximum medical improvement (MMI) and impairment rating (IR). On X, X was X. The carrier had accepted the following conditions: 1. Cauda equina syndrome. 2. Traumatic epidural spinal hematoma and arachnoiditis at X. Multiple records were reviewed. On X, X, MD saw X for impairment rating evaluation at the request of the treating doctor. X placed X at MMI on X with X impairment of the whole person. X stated X was being followed at X on an as needed basis. At the time, X was working X. X had driven to the appointment at the time. X ongoing complaints included constant X. X rated the pain at X. X was complaining of X. X was complaining of X. X also complained of having X. X also complained of X. X stated that once X. X stated X used a X. X weight was 142 pounds. The thoracic / lumbar spine examination revealed X. X was noted. X could stand on X toes and heels X times repeatedly without difficulty. X had a healed lower thoracic surgical scar measuring X. X was noted over the thoracic or lumbar spine. Lumbar range of motion showed flexion X degrees, extension X degrees, and right and left lateral flexion X. The X was X. Deep tendon reflexes were X at right and left knee and X at right and left ankle. X was noted to have X. The rest of X was X. X was noted to have X. The rest of the X. The impression was cauda equina syndrome and traumatic epidural spinal hematoma and arachnoiditis at X. Regarding maximum medical improvement (MMI), Dr. X stated, “MMI is defined as the earliest date after which, based on reasonable medical probability, further material

recovery from or lasting improvement to an injury can no longer reasonably be anticipated. Given this definition and based on the available documentation and today's evaluation, the claimant reached MMI on X, which is the date on which X was evaluated by Dr.X. Prior to this date, X was seen by Dr.X, the Designated Doctor on X who found X not to be at MMI, as additional diagnostic testing was pending. X did X. Since the claimant has X. Based on today's evaluation, there has been no significant improvement after X." Regarding impairment rating, Dr. X stated, "Based on the available documentation and today's evaluation, the patient belongs in X." In conclusion, X impairment rating was X impairment of the whole person. Dr. X documented that X respectfully disagreed with Dr. X impairment certification of X impairment of the whole person. This was because of the fact that based on the operative report, the epidural hematoma was at X. Hence, the proper X. However, Dr. X placed X at X. Hence, the X impairment of the whole person certified by Dr. X was invalid. A prescription dated X, by Dr. X for X was documented. 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 proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines conditionally recommend X. On X, the claimant was seen for designated doctor exam and reported X. The pain level was X. The claimant reported X. On the exam, the claimant X. There is X to the lumbar or thoracic spine. Lumbar range of motion was X. There was X. Reflexes were X. There was X. There was X of X. The claimant noted to have X. Lumbar MRI dated X and noted X. At X, there was X. Lumber MRI dated X noted X. The medical record provided is X. There is no documentation for the claimant's current symptoms and exam findings to clarify a need for this X item at this time. As such, the request for X is noncertified. "On X, Dr. X wrote an appeal letter stating, "This letter is in reference to the above claimant, in regard to a denial for X as per Utilization review notice received on X. X has a history of X after

injury on X. Since X injury, X has been working X. X states X is extremely uncomfortable and X still is experiencing X. X is requesting an X." Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Per the Official Disability Guidelines X is recommended generally if there is a medical need and if the device or system meets Medicare's definition of X to include it can X. Most X. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. The claimant had a history of X. The claimant had been X. The claimant reported the X. However, there were no recent clinical notes provided with subjective and objective findings with evidence of functional deficits and there was no documentation of X. As such, the request for X is not medically necessary. I discussed the case with Dr X, who provided no new clinical information as such the request remains not medically necessary. Thoroughly reviewed provided records. Patients can benefit from various X. In this case, the patient has X. However, there is no evidence to support X. Patient does not meet cited ODG criteria. While it is mentioned that X has X. 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:

Patients can benefit from X. In this case, the patient has X. However, there is no evidence to support use of X. Patient does not meet cited ODG criteria. While it is mentioned that X has X. 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)**