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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 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 injured while X was X. The diagnosis was other spondylosis of lumbar region. On X, X, PA-C evaluated X for follow-up of imaging results. X had a history of X. X presented to discuss surgery. X reported persistent

bilateral leg pain. X reported “good and bad days” and persistent right big toe numbness. On examination, X blood pressure was 182/104 mmHg, weight was 183.65 pounds, body mass index (BMI) of 26.9 kg/m2. X ambulated independently. Lumbar spine revealed no pain, spasms or bony abnormalities. X tandem gait was normal. X gait and station were normal. Various surgical and non-surgical options were discussed including Vitamin D / Calcium supplementation, consideration of epidural steroid injection (ESI), and bone stimulator as well as X fusion with microforaminotomy. X would like to proceed with surgery. A CT myelogram of lumbar spine dated X revealed prior X anterior lumbar interbody fusion. Graft material had been incorporated into the superior X and inferior X endplate but a prominent horizontal lucency coursed through the graft and solid interbody fusion was not evident. There was bilateral X spondylosis, grade X spondylolisthesis X on X was unchanged through the range of motion. Canal and subarticular recesses were within normal limits. There was mild bilateral foraminal stenosis. The other lumbar levels were within normal limits. Treatment to date included medications (X.Per a utilization review adverse determination letter dated X by X, MD, the request for X as requested by X, PA with X, MD at X was denied. Rationale: “Official Disability Guidelines (ODG by MCG) Low Back (Last review / update date:X) Fusion (Spinal) for Low Back Conditions Body system: Low Back Treatment type: "Surgery Conditionally Recommended as an option for spondylolisthesis, pseudarthrosis, unstable fracture, dislocation, acute spinal cord injury with post-traumatic instability, spinal infections with resultant instability, scoliosis, Scheuennann's kyphosis, or tumors, as indicated in the Patient Selection Criteria below. Not recommended in workers' compensation patients for degenerative disc disease (DDD), disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or nonspecific low back pain, due to lack of evidence or risk exceeding benefit. ODG Criteria Patient Selection Criteria for Lumbar Spinal Fusion: (A) Recommended as an option for the following conditions with ongoing symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated, eg, acute traumatic unstable fracture." “The patient is a X-year-old who sustained an injury on X. The submitted medical records do not demonstrate the presence of instability based on dynamic radiographs. In addition, there is no indication of loosening of implants at X. Guidelines have not been met for the requested procedure. The requested X is not medically necessary and is denied. “Per an appeal determination denial / reconsideration / utilization review adverse determination letter dated X, X, MD

denied request for X as requested by X, MD at X. Rationale: “The Official Disability Guidelines conditionally recommend spinal fusion for low back condition when certain criteria are met. On X, the claimant was seen for a follow up visit and reported pain to the lower back with radiation to the bilateral legs and persistent right big toe numbness. The claimant is X on X. On exam, lumbar spine noted with no pain, spasm, or bony abnormalities and had full range of motion. Lower extremity strength X of X bilaterally. Reflexes were X of X to bilateral upper and lower extremities. Sensation was normal to light touch. The claimant noted with normal gait. Lumbar MRI report dated X impression: Prior X anterior lumbar interbody fusion. Graft material has been incorporated into the superior X and inferior X endplate horizontal lucency courses through the graft, solid interbody fusion is not evident. Bilateral X spondylosis. Grade X spondylolisthesis X is unchanged through the range of motion. Canal and subarticular recesses are within normal limits. There is mild bilateral foraminal stenosis. The other lumbar levels are within normal limits. This request was previously reviewed and denied as the submitted medical records do not demonstrate the presence of instability based on dynamic radiographs as well as there is no indication of loosening of implants at X. While there is documentation for pain to the claimant's low back with radiation to bilateral lower extremities, there is no objective documentation for impairment or instability to the lumbar spine. As such, the request for X; date of service X is noncertified.”On X , a prospective review (M2) response was included in the records for the denial of X as requested by X, MD at X.The claimant has continued with persistent lower back and radicular leg pain status post anterior lumbar interbody fusion performed at X. The claimant had not improved with X. The recent imaging clearly noted X. In this case, the X is not being requested to address instability as noted in the previous denial rationales. The purpose of the proposed X is to address the X at X evident on CT. This is not going to be addressed through non-operative means. Given the continuing radicular pain in the X and X distributions, X would be appropriate during the revision procedure. Therefore, it is this reviewer’s opinion that medical necessity for the surgical requests is established and the prior denials are overturned. X is medically necessary and certified

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

The claimant has continued with persistent lower back and radicular leg pain status

post anterior lumbar interbody fusion performed at X. The claimant had not improved with X. The recent imaging clearly noted X at X on CT. There is clearly no solid incorporation of the interbody graft at X. In this case, the X is not being requested to address instability as noted in the previous denial rationales. The purpose of the proposed X is to address the X at X evident on CT. This is not going to be addressed through non-operative means. Given the continuing radicular pain in the X and X distributions, X would be appropriate during the revision procedure. Therefore, it is this reviewer's opinion that medical necessity for the surgical requests is established and the prior denials are overturned. X)is medically necessary and certified
Overturned

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