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An Independent Review Organization
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Notice of Independent Review Decision

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:

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who sustained an injury on X. X picked up a pallet that weight about 65 pounds and X and lost bladder control. The diagnoses included other intervertebral disc degeneration, lumbar region; spinal stenosis, lumbar region; other idiopathic scoliosis, lumbar region; lumbar radiculopathy; spinal instability, lumbar region; and spondylolisthesis, lumbar region. It was noted that X continued to have X the right leg with X. X had failed conservative treatment consisting of X, muscle relaxers, injection, and physical therapy. X was seen by X, MD on X for lumbar spine pain. X rated X pain 8.5/10. X continued to experience X. X often experienced numbness and tingling in X leg, but sometimes a burning

sensation and pain as well. X was unable to walk for long periods of time and required a cane for stability. X also endorsed right knee weakness causing X to fall a X. X was ready to move forward with X. X had seen X for clearance of X. X quit smoking in preparation for the X. On examination, X presented with discomfort related to the area of injury. X gait was unsteady revealing poor balance and coordination. X used a cane to ambulate. X experienced lower extremity sensation less, along the right X. Lumbar spine examination revealed scoliosis, tenderness over palpation, and positive straight leg raise / X test. Lower extremity strength was 4/5 bilaterally. On X, X underwent a psychological evaluation. it was opined that there appeared to be no significant psychosocial contraindications to surgery and the procedure could be scheduled as soon as it was medically necessary. X-rays of the lumbar spine on X demonstrated severe multilevel lumbar spondylosis; retrolisthesis at X; and mild loss of vertebral body height at X which could be due to previous compression fracture injuries and / or due to advanced spondylosis and degenerative changes causing excessive axial loading stresses, that was favored, given the significant lumbar scoliosis convex left was present which likely contributed to excessive axial loading stresses. An MRI of the lumbar spine on X showed X. An EMG/NCV dated X of the lower extremities showed no evidence of X. Treatment to date included medications (), injections, physical therapy, lumbar injection, and activity restrictions. Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “The injured worker's previous denial was because of ongoing smoking however, X has reportedly stopped. The documentation does not include a psychological evaluation by an independent mental health provider and does not include PT documentation. The request for X is not medically necessary . Per the utilization review by X, MD, PhD on X, the request for X was non-certified. Rationale: “The request for X was denied on X by Dr. X due to no documentation of a psychological evaluation by an independent mental health provider and no documentation from PT. Regarding X, ODG notes that X is indicated in cases when all physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts, including skilled therapy visits and performance of home exercise program during

and after formal therapy; x.-rays demonstrating spinal instability and/or myelogram, CT·myelogram or MRI demonstrate nerve root impingement correlated with symptoms and exam findings; X is to be performed at one or two levels; and the psychosocial screen is obtained with confounding issues addressed X is recommended as an option for spondylolisthesis with instability and/or symptomatic radiculopathy and/or symptomatic spinal stenosis in patients with ongoing symptoms, corroborating physical findings and imaging, and after the failure of non-operative treatment. In this case, there is no documentation to support that psychological clearance from an independent mental health provider has been obtained. There is also a plan to obtain updated imaging studies, and there is no documentation to support that these were performed. Thus, the medical necessity of the requested X is not established. Recommend non-certification." The requested X procedure is not medically necessary. The submitted medical records do indicate that the patient has undergone a psychological evaluation without any type of confounding variables. However, the submitted medical records do not indicate the presence of instability in the lumbar spine. Given the lack of instability in the lumbar spine, there is no indication to proceed with the requested X. No new information has been provided which would warrant the requested procedure. 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 requested X is not medically necessary. The submitted medical records do indicate that the patient has undergone a psychological evaluation without any type of confounding variables. However, the submitted medical records do not indicate the presence of instability in the lumbar spine. Given the lack of instability in the lumbar spine, there is no indication to proceed with the requested X. No new information has been provided which would warrant the requested procedure. 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