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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 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 reported, X and a X. The diagnosis was low back pain and lumbar radiculopathy. On, X was evaluated by X, MD for complaints of low back pain. X complained of low back pain and right lower extremity pain that extended on the lateral aspect into the big toe. X also reported intermittent symptoms in the left lower extremity, but overall, this was greater on the right leg. Overall, the low back pain bothered X the most. X previously had tried X. X reported X. X reported X continued to work X. X returns on that visit following X results of the lumbar spine. Overall, X rated the pain at the time as X. On physical examination X. The lumbar spine examination revealed range of motion of flexion (X degrees) with pain and extension (X degrees) with pain. On X testing, the X.X. The neurological examination showed X. X on the right was positive and reproduces X. The assessment was low back pain and lumbar radiculopathy. Dr. X noted that X presented with lumbar spondylosis at X. X complained of right-greater-than-left radicular symptoms down the lateral aspect of the leg into the big toe on the right as well as weakness in the right leg. X had severe stenosis at X with X disc herniation. Due to the failure of X. An X of the lumbar spine dated X revealed straightening of the lumbar lordosis indicative of back pain and/or muscle spasms. At the X level, there was a X mm posterior disc herniation, eccentric to the right. There was X. There was also X. The AP diameter of the central canal was markedly narrowed to X mm. Treatment to date included X, Per a utilization review adverse determination letter and peer review report dated X by X, MD, the request for X was denied. Rationale: “The claimant has no evidence of instability and there have been no previous surgical procedures on the L spine such as previous discectomy. The claimant has not had a mental health evaluation, either. Therefore, X is not medically necessary. “Per a reconsideration review adverse determination letter and peer review report dated X by X, MD, the request for X was denied. Rationale: “The same materials were submitted for

review and are unchanged from the previous determination. There is no evidence that these has been a mental health evaluation done by an independent practitioner and there is not evidence of proven instability that meets ODG criteria. Therefore, the request for X is not medically necessary. “The requested surgical procedure is not medically necessary. The submitted the medical records do not document instability at the X. There is no indication of a pre-surgical psychological evaluation. Furthermore, the guidelines do not support X. Thus, no new information has been submitted which would overturn the previous denials. 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 not document instability at the X. There is no indication of a pre-surgical psychological evaluation. Furthermore, the guidelines do not support X. Thus, no new information has been submitted which would overturn the previous denials. 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