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Notice of Independent Review Decision
Amendment x
Amendment x

IRO REVIEWER REPORT

Date:X; Amendment 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 working on X. The diagnosis was lumbar intervertebral disc disorder with radiculopathy at X ; lumbar disc prolapse with radiculopathy, wedge compression fracture of first lumbar vertebra, wedge compression fracture of second lumbar vertebra, low back strain, and lumbar sprain. X was seen by X, DO, on X for a follow-up visit. X was pending control of X to proceed with surgery. The last labs drawn on X, X was greater than X and X. X was seen by an internal medicine (IM) doctor and would be starting X soon. The X that morning was X. The low back pain (LBP) seemed to be increasing with radiation to lower extremities (LE's), left greater than right and weakness to left LE. An electromyography (EMG) report dated X revealed X. On examination, X blood pressure was X, weight was 193 pounds and BMI was X. The physical examination revealed lumbar / trunk range of motion in flexion was X degrees with pain and extension was X degrees with pain. There was tenderness to palpation at lower left paraspinal muscles of lumbar spine. Sensory examination revealed decreased pinwheel sensation to posterior / lateral left leg and slight decreased to anterior left leg. There were functional deficits present while X. Straight leg raise test was X on the left at X degrees and on right at X degrees. X test was X on the left. Cross leg lift test was X bilaterally, left greater than right. X test was X on the left. There was difficulty X. Regarding maximum medical impairment, X had not reached at that time. The work status included X. X was advised to follow-up with Dr. X and with Dr. X for pending control of X. On X, X, MD evaluated X for X week follow-up of back pain. X complained of left greater than right leg pain. The pain was located in the back of the leg. The severity of pain was rated x. X had x. X had difficulty with x. Treatments included X. On examination, X weight was 187 pounds and body mass index (BMI) was X. Motor strength was X in bilateral deltoids, right iliopsoas, left quadriceps, and left hamstrings, and X in left iliopsoas and bilateral extensor hallucis longus / tibialis anterior. Sensation was decreased X. X was X. X had tried X. X had weakness and numbness on examination. X would benefit from a X. X would like to proceed with operation. An MRI of lumbar spine dated X showed X. An anterior compression deformity of X with approximately X anterior height loss. At X level, there was X. The central canal was slightly X. There was X. There was moderate X. At X level, there was X. There was X. There was X. The X was X. There was X. There was X. At

X, there was mild X. There was a X. The X. There X. At X, there was X. There was X. There was X. There is X. There was 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: “The claimant had continued with ongoing lower back and left leg pain. The claimant had been treated with X. No physical therapy or procedure records were included for review detailing failure of non-operative measures to date. A pre-operative psychological evaluation of the claimant was not included for review ruling out any confounding issues that could impact post-operative outcomes as recommended by current evidence-based guidelines. The current lumbar imaging detailed X. The current evidence-based guidelines do not recommend X. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the X requests. As the surgical requests are not indicated, there would be no requirement for a X.” On X, Dr. X provided an appeal letter for the denial of X. Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: “The requested X is not medically necessary. The submitted medical records do not indicate the presence of instability. An EMG report does demonstrate X. Preoperative psychological evaluation has been completed. However, the guidelines have not been met due to the lack of instability present in the lumbar spine. Therefore, the requested appeal for X is not medically necessary. “In review of the clinical findings, the claimant had been followed for ongoing chronic lower back and leg pain with imaging X. The claimant had not improved with X. The claimant did obtain a psychological evaluation ruling out any contraindications for surgery. However, the available imaging reports did not detail evidence of any X. The current evidence-based guidelines do not recommend X. Therefore, it is this reviewer’s opinion that medical necessity for the requests has not been 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:

In review of the clinical findings, the claimant had been followed for ongoing chronic lower back and leg pain with imaging detailing X. The claimant had not improved with X. The claimant did obtain a psychological evaluation ruling out any contraindications for surgery. However, the available imaging reports did not

detail evidence of any X. The current evidence-based guidelines do not recommend X. Therefore, it is this reviewer's opinion that medical necessity for the requests has not been established and the prior denials are upheld. 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)**