US Decisions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 US
Austin, TX 78731
Phone: (512) 782-4560
Fax: (512) 870-8452
Email: @us-decisions.com

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 Overtuned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X with date of injury X. X sustained an injury to X lower back when X was X. The assessment included radiculopathy of lumbar region, intervertebral disc disorders with radiculopathy of lumbar region, other low back pain, spondylolisthesis of lumbar region, spondylolisthesis of lumbosacral region, osseous and subluxation stenosis of intervertebral foramina of lumbar region, radiculopathy of lumbosacral region and intervertebral disc disorders with radiculopathy of lumbosacral region. On X, X was seen via telemedicine by X, MD for complaints of severe low back pain. At the time X was experiencing pain in their right thoracic, posterior right flank, left thoracic, posterior left flank, right buttock and posterior right thigh. X rated the percent distribution of X pain as X back and X leg. The pain was described as burning / hot, deep, numbness, penetrating, sharp, shooting, tender, throbbing and tingling. The pain was rated at a X at the time and getting worse. Symptoms were exacerbated by standing, sitting, lifting, bending forward, and seemed to improve with X. Pain radiated to the right lower extremity and the leg pain was rated as. Examination was unremarkable. Due to the chronicity of X pain as well as to address the severe stenosis, retrolisthesis and disc height loss, Dr. X recommended to proceed with X. X would X. X for home was X. On X, X had a Presurgical Behavioral Health Evaluation by X, Ph.D. for assessment of X ongoing emotional condition and psychological suitability for X. At the time X pain was in the lumbar region, which X described as burning, aching, radiating pain with numbness. X reported pain X. X pain increased with activity and physical exertion. X reported that changing postures helped relieve X pain the most. X had been treated with X. Mental status examination was unremarkable. “On the Pain Patient Profile (P-3), Depression score X, Below Average for pain patients. Somatization score was X, Below Average score for pain patients. Fear-Avoidance Beliefs Questionnaire (FABQ) scores indicated that X does not exhibit a high fear of physical activity, X and X score on the Work Scale. X Depression Inventory score was X and Beck Anxiety inventory score was 0. On the PAIRS, the patient obtained a low score of X , that is in the very functional direction and suggests that this

patient understands the importance to be functional and active in spite of discomfort and pain. Oswestry Disability Index score was X, which is an elevated score." Dr. X concluded, "X does not exhibit psychological or behavioral risk factors shown in the literature that predict a poor spinal surgery outcome. Based on Block's model, X falls in the "fair prognosis" category, thus my recommendation for X. "An MRI of the lumbar spine dated X showed at X. This disc extrusion impressed on the descending left X nerve roots. Mild spinal stenosis and moderate bilateral neuroforaminal narrowing at this level was noted. At X-X, a disc bulge and retrolisthesis, and facet arthropathy caused severe right and moderate to severe left neuroforaminal narrowing. Mild neuroforaminal narrowing bilaterally at X and minimal at X was noted. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "In this case, the claimant is a X being treated for low back pain radiating bilateral leg symptoms. The MRI dated X, revealed a X. This extrusion impresses on the descending left X nerve roots. Mild spinal stenosis and moderate bilateral neuroforaminal narrowing at this level; 2. At X a disc bulge and retrolisthesis, facet arthropathy causes severe right and moderate to severe left neuroforaminal narrowing; 3. Mild neuroforaminal narrowing bilaterally at X-X and minimal at X. On X, the claimant followed-up with complaints of severe low back pain with radiating bilateral leg symptoms pain score seven to eight out of ten (X). The treatment has included X. The examination findings lumbar spine not reported. The medical records noted a mild retrolisthesis on imaging, however there are no objective findings of instability on examination, nor is there x-ray findings of lumbar instability to support the fusion procedure. The medical records do not provide evidence of an MRI demonstrating nerve root impingement correlated with symptoms and examination findings; Psychological Screening for Low Back; objective findings which confirm presence of radiculopathy on examination at the request level nerve root distribution to support X procedure; therefore, the request for X is not supported. Dr. X wrote a letter on X, in response to the denial letter dated X stating, "Patient has evidence of spondylolisthesis on both x-ray and MRI. In addition to this, the patient has severe facet arthrosis at both X and X resulting In moderate foraminal narrowing bilaterally at X and moderate to severe left foraminal narrowing at X and severe right sided foraminal narrowing at X. In order to adequately address both the severe foraminal narrowing, which is causing nerve impingement as evident on

the MRI from X as well as address the instability of X and X, the surgery is required to remove the facet joints to decompress the impinged nerves and then further stabilize the bones where there is spondylolisthesis. 2. The denial letter states there is no lumbar spine examination present, however this is also inaccurate as there was a full physical exam from office visit dated X and it was only the telemedicine visit on X where we reviewed the MRI that an in person physical exam was not performed due to the virtual nature of the visit. On x-ray the amount of spondylolisthesis at X measures closes to X on neutral and X on extension. Additionally, at X, there is X of retrolisthesis on extension. Therefore, while the denial letter states there are no objective findings of instability on exam, these findings on X-ray would refute that claim. 3. Once again the letter states there is no MRI demonstrating evidence of nerve root impingement, while the MRI from X clearly demonstrates moderate to severe foraminal narrowing on both sides at X and X. Additionally, the patient has been reported multiple times in the medical record to complain of severe low back pain with R > L buttocks and radiating leg pain. 4. The patient has undergone a psychological screening, which shows X to be psychologically cleared to undergo spinal fusion. 5. The reason a laminectomy alone is not adequate to address the patient's issue is due to the areas of stenosis, namely the severe foraminal stenosis which will require removal of the facet joints to adequately decompress as well as underlying spondylolisthesis requiring fusion to stabilize any instability which was either pre-existing' or made iatrogenically.”Per a reconsideration review adverse determination letter dated X by X, MD, the previous denial for the request for X was upheld. Rationale: “The patient is a X who sustained an injury on X. The patient had been followed for ongoing lower back pain which increased with any activity or physical exertion. The patient was referred for preoperative behavioral health evaluation which was completed on X and found no contraindications for surgery. The records did not include any recent imaging reports for the lumbar spine detailing evidence of significant spondylolisthesis or motion segment instability at X or at X. Pre-operative treatment was not detailed such as physical therapy reports, injection procedure reports, or medications. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request. Therefore, the requested X is denied. “Based on the medical documentation, the requested surgical procedure is not medically necessary. The medical records indicate that the claimant predominately has axial

back pain with X of the pain being in the back and X being in the leg. The records do not demonstrate any evidence of a dermatomal distribution of pain, sensory deficits or weakness. The guidelines do not support lumbar fusions for primary axial back pain. 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:

Based on the medical documentation, the requested surgical procedure is not medically necessary. The medical records indicate that the claimant predominately has axial back pain with X of the pain being in the back and X being in the leg. The records do not demonstrate any evidence of a dermatomal distribution of pain, sensory deficits or weakness. The guidelines do not support X for primary axial back pain. 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)**