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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 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. The diagnosis was spondylosis of the lumbar region and spinal stenosis of lumbar region with neurogenic claudication. X was evaluated by X, PA-C /X , MD on X for follow-up to review imaging. X was seen by Dr. X for consultation and evaluation with complaints of X back pain and X left lower extremity pain. X reports pain started in X. X back pain progressively worsened a X. described the low back pain as throbbing and stabbing pain that was greater on X left than X right side. X back pain radiated to the left buttock and continued laterally to the ankle. X reported X. X reported associated X. X had a X. X reported X. X reported changes in X; when X. X reported daily average pain X and with medication X. X reported the pain was worsened by X. It was improved X. X had tried X. On examination, X ambulated without assistance. musculoskeletal examination noted a X. The MRI from X was reviewed. The assessment was lumbar spondylosis. Treatment options were discussed including X. Due to X structural pathology findings on MRI of significant spinal stenosis at X and neurogenic claudication, an X laminectomy was recommended. X would like to proceed with X. X x-rays were ordered and consent for the procedure was scheduled. On X , X was evaluated by X, FNP-C /X , MD for a pain management office visit. X reported radiating low back pain described as X. It was alleviated by X. It was aggravated by X. X were disturbed and overall function had not improved. At the time, X stated the X. X had taken a X and the symptoms had improved. X requested an X. It was noted that X pain had decreased X functionality and decreased X quality of life. On examination, X was X. X was diminished on the lateral lower left leg. X were diminished. X was slightly weaker than the right, X. A X was noted on the right and left. X was decreased. It was tenderness to palpation and pain was reproduced with facet loading maneuvers. There was a X. X was discontinued and X restarted. X had been ordered. X was continued. An MRI of the lumbar spine dated X demonstrated X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Official Disability Guidelines recommend X. Official Disability Guidelines recommend X. On X, X presented with low back pain that is greater on X left than X right side. X back pain radiates to the

left buttocks and continues laterally on the ankle. X reports X. X has a X. X reports X. Pain level was X and with medication X. Previous treatments include X. Examination showed X. X was diminished in X right and left. Magnetic Resonance Imaging of the lumbar spine showed X. There is X. In this case, it was noted that the claimant was found to have X. However, there was no documentation that the claimant underwent X. The guidelines criteria are not met. As such, the medical necessity has not been established for X."A letter of medical necessity dated X was documented by X, MPAS, PA-C, documenting that in X, X. X had tried and X. X was evaluated by neurosurgery on X, with follow-up with updated imaging on X. Due to X structural pathology findings on MRI of significant X was recommended. X was motivated and determined to regain X quality of life. No other conservative treatments suggested provided benefit and X had tried and failed those that would possibly provide some relief. X further noted, "Multiple attempts to perform peer to peer review were made and even with scheduled appointments for reviewing case never occurred because physician reviewing case was not available and never returned calls, as well after leaving messages with the staff." X opined that X X. This procedure would improve X pain and symptoms in hopes X could be an active adult as X was prior to the incident and work again to provide for X family. Per a reconsideration review adverse determination letter dated X , the request for X was denied by X, MD. Rationale: "In this case, the patient sustained an injury to the lumbar spine on X. An MRI was obtained on X. At X. On X. The patient reports low back and left leg pain. There is a X. Regarding this request, the X is not medically necessary. The records do not demonstrate a X. The MRI scan is unchanged from previous scans. As such, the guidelines have not been met. As such, the request is not medically necessary and the appeal is upheld." The claimant had presented with continuing lower back and bilateral leg pain with MRI studies demonstrating stenosis at X. The claimant's physical exam findings noted X. The claimant had X. Therefore, it is this reviewer's opinion that medical necessity 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 had presented with continuing lower back and bilateral leg pain

with MRI studies demonstrating X. The claimant's physical exam findings noted X. The claimant had X. Therefore, it is this reviewer's opinion that medical necessity 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**
- ☒ **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)**