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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 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 at work on X. X was X. The assessment was X. On X, X was evaluated by X, MD for a follow-up of back pain and leg pain. X continued to have severe low back pain and right lower extremity radiating pain with numbness and

tingling. X felt weakness in the right leg and also some weakness and tingling in the left leg. X had X recently without significant benefit. That affected X quality of life and X ability to work. X rated leg pain X and low back pain X. On examination, X body mass index was 32.67 kg/m2. Physical examination revealed minimal pain with lumbar extension. There was X. X had significant X. On assessment, X had ongoing pain with X. X had X. At the time, light duty was advised. X had significant . X also had X related to X original date of injury on X. Treatment plan included to proceed with X .On X, was evaluated by X for follow-up visit. X continued to have significant symptoms and radiating pain into the right lower extremity. X surgery was denied by Worker's Compensation. X rated mid back pain X, leg pain X, and low back pain X. On examination, X blood pressure was 155/91 mmHg. Physical examination was unchanged. X obtained an ombudsman to help navigate with the appeal. X symptoms were directly related to X work injury. X had prior X. That was progressed over time into X. It was a natural phenomenon after the injury and well documented in the medical literature. Therefore, ongoing symptomatology was directly related to the original injury and therefore recommended X would be also related to the original injury and medically necessary. It was an approved procedure for X condition. The appeal was recommended from a legal standpoint. Workers Comp. had approved X. An MRI of the lumbar spine dated X revealed a previous X had been performed. A X was present that X. The X was X. The X was present that X. The X was present. The X was present. Treatment to date included X. Per the adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per ODG X, “not recommended for X. Evidence Summary: A systematic review of X. “In this case, the patient sustained an injury to the lumbar spine. An MRI revealed that at X has been performed. There is a X. At X, there is a X. X is noted at X. On X, the patient reports low back and right leg pain. Regarding this request, X is not medically necessary or appropriate. The medical records do not demonstrate that the patient has completed a X. In addition, the guidelines do not support X. As such, the guidelines have not been met and the request is non-authorized. “Per the adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Official Disability Guidelines do not recommend X. On X, the claimant presented with significant symptoms and radiating pain into the right lower extremity with weakness and numbness in the left lower extremity. Mid back pain was X. Leg pain was X. Low back pain was X. Lumbar spine examination showed X. X has significant X from X previous exam. X is status X. Lumbar MRI showed X. A prior review dated X

non-certified the request for X. In this case, there is still no information provided if the patient has X. Guidelines do not recommend X. There are X noted that will support going beyond the guideline's recommendations. As such, the medical necessity has not been established for the Reconsideration Request for X." The requested surgical procedure consisting of a X is a not medically necessary. The guidelines do not recommend X. No new information has been provided 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 surgical procedure consisting of a X is not medically necessary. The guidelines do not recommend X. No new information has been provided 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