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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 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 a X and reported that on X, while at work, X was watching X. The diagnosis was lumbar radiculopathy; other intervertebral disc displacement, lumbar region; and foot drop of the right foot. On X, X was evaluated by X, MD for the chief complaint of low back pain and right lower extremity pain for X year and X months. X reported pain to the right of the midline of the lower lumbar spine that was sharp, shooting, electrical, was constant and rated X. The pain worsened with extension; worsened when standing; woke X from sleep at night (the last time was the previous night); and going from sit to stand. It was alleviated by sitting (in the recumbent position); lying down (flat on back); position change; and X. X also reported associated pain down the right buttock into the posterior thigh into the posterior calf into the big toe and two toes next to it. X reported numbness and tingling down the right lower extremity in the same distribution as the pain, and reported weakness of the right lower extremity. X also reported walking distance was limited to X blocks, and stated X stopped and rest or lay down. Examination noted X. The lumbar spine showed tenderness on the midline and either side of midline of the lower lumbar spine. Strength examination showed X. The right and left ankle reflexes were absent. Sensation on the right was X. X was X. An MRI study of the lumbar spine done on X was reviewed and showed X. There were other changes as well noted in the report. Plain radiographs of the lumbar spine done at the time showed X. X was maintained. X was preserved. X was seen. The assessment X. X were ordered. X was prescribed. X was recommended. Dr. X opined as follows: “X walked with X. When asked to heel walk X demonstrated a X. X also had difficulty with toe walking. X had a healed midline scar in the lower lumbar spine. X had marked limitation of flexion and extension. The was X on the right but X on the left. X showed X. X was diminished over the X. There was absence of the X. Both X were X. X has a right sided foot drop following X work injury with associated radiculopathy. I recommend a right-X.”X-rays of the lumbar spine done on X were reviewed. The study showed: X was maintained. There was X. There was X. X were seen and no abnormal soft tissue shadows. There was X. Treatment to date included medications X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Based on the clinical information submitted for this review and using the

evidence-based, peer reviewed guidelines referenced below, this request is Non-certified. As per ODG, X is conditionally recommended. ODG indications for surgery X required symptoms/findings; imaging studies; and conservative treatments below: Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. X should correlate with symptoms and imaging. C. X nerve root compression, requiring ONE of the following: 1.X; 2.X 3.X:X. As per medical record dated X, the claimant continued to have low back pain and right lower extremity pain for X. Pain worsened with extension, standing; going from sit to stand; and wake X from sleep at night. Pain relieved with sitting, lying down, position change and medications X. X had numbness and tingling down the right lower extremity in the same distribution as the pain. X motor strength on the right revealed X. Ankle reflex was absent bilaterally. There was decreased X. X was X. Based on the medical records available for review, the claimant had subjective complaint of low back pain rated at X. Despite receiving X, none of these treatments proved effective. Although the subjective and objective findings support the medical necessity of the request; guidelines indicate diagnostic imaging modalities, which is not documented in the available medical records. Guideline criteria is not met. There are no additional information available to override previous determination. Hence, this request is not medically established." Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced below, this request is Non-certified. According to evidence based guidelines, X is recommended indicated below when a radiographically demonstrated abnormality supports clinical findings consistent with one of the following: progression of myelopathy or focal motor deficit; intractable radicular pain; or presence of spinal instability when performed in conjunction with stabilization. Surgery is not recommended for X. Completion and failure of at least X weeks of conservative care, unless progressive neurologic deficit, tumor, infection, central cord syndrome, hyperextension injury, facet subluxation, fracture/dislocation, foreign body, epidural hematoma, or major instability. In this case, the claimant was injured on X. X treatment consisted of X and none of these have proven to be effective. X was status X. X was also status post X. X had X. On X most recent medical report dated X, X symptoms have continued to worsen; X has failed most conservative treatment. X exhibited

antalgic gait. There was tenderness over the mid line and either side of mild line of the lower lumbar spine. X had failed conservative management, but there is no documentation regarding recent imaging studies. Hence, the request for X is noncertified." Based on the submitted medical records, the requested procedure is not medically necessary or appropriate. The surgical request includes a X. The imaging report does not demonstrate the presence of a 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:

NA

Based on the submitted medical records, the requested procedure is not medically necessary or appropriate. The surgical request includes a X. The imaging report does not demonstrate the presence of a 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**
- ☒ **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**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**