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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 on X. X had a history of back pain beginning in X resulting in X. X reported X. X did use a walking stick in the community due to fear of falling. The diagnosis was chronic bilateral low back pain without sciatica.

X had a physical therapy initial evaluation on X by X, PT. X continued to experience mid back pain resulting in difficulty with ambulation, stair negotiation, activities of daily living, household chores and sleeping. The pain was rated X. X had difficulty with prolonged sitting / standing, performing normal household chores, dressing lower extremities, walking limited to X minutes with use of walking stick, and disturbed sleep. The back index score was X and ABC score was X impaired. The MRI of the thoracic spine showed X. There were X. X was noted. On examination, active range of motion of the lumbar spine showed right side bending unable past neutral with pain, left side bending X, right rotation X and left rotation X with pain. Muscle strength was X during flexion and abduction of right hip, X during right knee flexion, and X during right knee extension. It was X during left hip flexion and left knee flexion, X during left hip abduction, and X during left knee extension. There was significant X, although, X was able to attain upright posture with discomfort. There was tenderness to palpation noted over X. There was X. X showed X was noted. X was noted with X. Straight leg raise test was X. Single leg stance was X. Functional testing revealed timed up and go X seconds without assistive device and five times sit to stand X seconds with upper extremity assist. It was assessed that X presented

with continued chronic thoracic and lumbosacral pain resulting in decreased functional strength and range of motion leading to deficits in activities of daily living including sleeping, prolonged sitting and standing, walking, and performing household chores. X had improved X. X continued to have co-morbidities and complexities that would most likely slow the rehabilitation process. X would benefit from continued X.

X had a physical therapy initial evaluation on X by X, PT. X complained of constant dull, aching and sharp pain across X mid back, as well as lower lumbar spine. The pain was rated X. X had increasing lower extremity weakness, which X felt was more from inability to remain active. X had recently noted increasing pain about X cervical region. The pain increased with prolonged standing / walking / sitting. X had recently begun taking muscle relaxants but had not felt much relief with that yet. X had difficulty with prolonged sitting / standing, performing normal household chores, dressing lower extremities, walking limited to X minutes with use of walking stick, and disturbed sleep. The back index score was X and ABC score was X impaired. The MRI of the thoracic spine showed X. There were no signs of X. X was noted. On examination, active range of motion of the lumbar spine showed flexion X with pain, extension unable past neutral with pain, right side bending unable past neutral with pain, left side bending X, right rotation X and left rotation X with pain. Muscle strength was X during flexion and abduction of right hip, X during right knee flexion, and X during right knee extension. It was X during left hip flexion and left knee flexion, X during left hip abduction, and X during left knee extension. There was significant X. There was tenderness to palpation noted over X. There was significant X. Sensation was X. There was X. X was slow and guarded but without notable instability. There was X." X was noted with X. Straight leg raise test was positive bilaterally. Single leg stance was X second on right side and X seconds on left side. Functional testing revealed timed up and go X seconds without assistive device and five times sit to stand X seconds

with upper extremity assist. X assessed that X presented with thoracic and lumbosacral mechanical derangement, decreased lower quarter joint and soft tissue mobility, decreased functional strength and postural stability resulting in faulty movement patterns and pain with activity. These deficits limited X ability to tolerate prolonged sitting, standing, walking, performing household chores, dressing X lower extremities, and sleeping at night. X presented with several co-morbidities / complexities that would most likely slow the rehabilitation process. However, X was very motivated to rehabilitation and was a good candidate for skilled physical therapy to address the above-noted deficits and return to being able to care for X home, walk community distances and sleep at night with decreased difficulty and pain. The plan included X.

A medical record review was documented on X by X, MD. It was opined that X treatment was related to X post laminectomy syndrome. The postoperative changes noted in the MRI of the thoracic spine were related to the work injury.

There were degenerative changes noted, which were not related to the work injury but rather findings commonly seen with the aging process. The recent diagnostic imaging revealed X medical status with respect to X work-related injury was static at the time. The documentation did not support progress from current treatment. X had chronic postoperative residuals that were related to the surgical intervention X received for X work-related injury. These would not be expected to improve. There was no indication for any additional office visits other than visits to supervise the use of prescription medication for chronic pain. There was also no indication for X.

Per a medical record review dated X, an MRI of the thoracic spine dated X showed X. There was X. X was noted. There was X. Similar changes were identified at X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was noncertified. Rationale: “The Official Disability Guidelines (ODG) X. In this case, the claimant has X. There is no evidence of significant improvement of pain or function with the most recent X. Additional certification will require evidence of X. As this request exceeds the guideline X by X, MD, the reconsideration request for X was noncertified. Rationale: “The ODG recommends up to X. The ODG does not recommend X for the treatment of low back pain. In this circumstance, the injured worker reports chronic low back pain. They have X. They have X. On exam, they have X. There is a request for X. When noting that the request exceeds guidelines and there is X. Additionally, there are X. As such, X is noncertified.”

Thoroughly reviewed provided records including provider notes, imaging findings, and peer reviews.

Patient with back pain issues for X.

However, patient has X. These X have X. 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:

Thoroughly reviewed provided records including provider notes, imaging findings, and peer reviews.

Patient with back pain issues for X.

However, patient has X. These X. 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:

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE