

IRO Express Inc.
An Independent Review Organization
2131 N. Collins, #433409
Arlington, TX 76011
Phone: (682) 238-4976
Fax: (888) 519-5107
Email: @iroexpress.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 Overturned Agree in part/Disagree in part
- Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X. X was X. The diagnoses were spondylolisthesis, lumbosacral region; low back pain, other intervertebral disc displacement in the lumbosacral region; intervertebral disc disorders with radiculopathy, lumbar region.

On X, X was seen by X, MD, for follow-up of X low back pain. X presented with prior X. X had X. X presented for X. This was still related to X work injury that caused X. The lumbar spine examination revealed X. Lumbar spinous process and lumbar posterior superior iliac spine was X. X was present. The range of motion was painful, limited, decreased and painful limited extension. Pelvis was level in standing position. FABERE test was X. Hip motion was X, painless range of motion (ROM), bilaterally. The sitting and supine straight leg raise test was X on the right. Lasegue test on the right was X. Gait showed X. The motor examination revealed X. The bilateral knee and ankle jerks were X. Sensory examination showed X. Pedal pulses were X. An MRI of the lumbar spine, dated X revealed X. The assessment was X. X presented with X. This occurred secondary to work injury that caused X. At that point, X would require X. On X, X was seen by Dr. X, for follow-up evaluation of X back pain. X was initially injured at work, and X had X. X had X. X continued to have severe back and leg pain which had X. The lumbar spine examination revealed X. X was present. The range of motion was painful, limited, decreased and painful, limited at extension. Pelvis was level in the standing position. FABERE test was X. Hip motion was normal, painless range of motion (ROM), bilaterally. Sitting and supine straight leg raise test on the right was X. Lasegue test on the right was X. Gait showed X ambulated without a limp. The motor examination revealed X. The bilateral knee and ankle jerks were X. Sensory examination showed X. Pedal pulses were X. X presented with a recurrent X. This X. The new MRI had showed X. X-rays were taken on the day, which were stated to show X. It was X. Due to instability and previous X.

Treatment to date included X.

Per a utilization review adverse determination letter / Peer Review Report dated X by X, MD, the request for X with surgeon X, MD, co-surgeon X, MD and assistant surgeon X, PA-C at X was denied. Rationale: "Based on the provided documentation, the patient has low back pain. A physical examination of the lumbar spine revealed a X. X straight leg raise. Lasgue is X. An MRI of the lumbar spine taken on X revealed X. Right laminectomy changes are seen. Small ovoid areas of signal alteration in X. No evidence of mechanical nerve root impingement. The patient has tried X. The patient currently has radicular pain as well. The Magnetic Resonance imaging (MRI) does not indicate significant X. Lumbar spine X-rays were not provided in the records. Therefore, the request for X with surgeon X, MD Co-Surgeon X, MD and Assistant surgeon X, PA-C at X is non-certified." "As the surgery request is non-certified, ancillary requests are non-certified. Therefore, the request for X is non-certified."

Per a utilization review adverse determination letter / Peer Review Report dated X by X, MD, the request for X with surgeon X, MD, co-surgeon X, MD, and assistant surgeon X, PA-C X was denied. Rationale: "The requested surgical procedure is not medically necessary. The submitted medical records do not indicate the X. The most recent MRI scan provided was from X, and it does not demonstrate any evidence of X. As such, the guidelines have not been met. Therefore, the request for X with surgeon X, MD Co-Surgeon X, MD, and Assistant surgeon X, PA-Cat X is noncertified."

Per a reconsideration review adverse determination letter dated X and a Peer Review Report dated X by X, MD, the appeal request for X with surgeon X, MD, co-surgeon X, MD, and assistant surgeon X, PA-C at X; X was denied. Rationale: "The request is not medically necessary. There is no instability at X. X is not considered instability and there is X. Therefore, the request is not medically necessary."

In this case, the claimant has continuing lower back and leg pain which has not improved with X. The claimant's current evaluation noted X. There was sensory

change noted in the X. However, the only formal imaging report included for review regarding the lumbar spine was from X and is years out of date. No more recent formal imaging reports of the lumbar spine were included for review demonstrating instability and spondylolisthesis at X. The current evidence based guidelines and literature does X. Therefore, it is this reviewer's opinion that medical necessity is not established for the services being requested and the prior denials are upheld. X with surgeon X, MD Co-Surgeon X, MD and assistant surgeon X, PA-C at 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:

In this case, the claimant has continuing lower back and leg pain which has not improved with X. The claimant's current evaluation noted X. There was sensory change noted in the X. However, the only formal imaging report included for review regarding the lumbar spine was from X and is years out of date. No more recent formal imaging reports of the lumbar spine were included for review demonstrating instability and spondylolisthesis at X. The current evidence based guidelines and literature does not recommend X. Therefore, it is this reviewer's opinion that medical necessity is not established for the services being requested and the prior denials are upheld. X with surgeon X, MD Co-Surgeon X, MD and assistant surgeon X, PA-C at X; X is not medically necessary and non-certified.

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