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Notice of Independent Review Decision
Amendment X

Sent to the Following

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:
PM&R/Pain Medicine

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was X. X was X. The diagnosis included classic post lumbar laminectomy pain syndrome with recurrent radiculopathy following work injury and failed surgical intervention and secondary myofascial pain syndrome with generalized deconditioning.

Per a Functional Capacity Evaluation dated X by an unknown provider at X it was noted that X had findings with X functional specific tasks that may interfere with performance of X job duties or activities of daily living. The required physical demand level (PDL) was heavy. However, X ongoing physical performance level was light. Recommendations included - according to the objective findings from the testing including PILE lifting and static lifting, the clinical examination and all other activities previously mentioned in the report, it was opined that X did not meet the requirements, safety, and performance ability to do X job safely, effectively, and confidently (without restrictions). X was not capable of performing their job duties (without restrictions) until they demonstrate objective improvement and the ability to perform safely and efficiently at their place of employment. High blood pressure was noted in the beginning of the evaluation. X was monitored and was able to safely complete most of the evaluation. X should be evaluated by the primary care physician. A psychological evaluation was recommended for X emotional complications as a result of the injury and the surrounding problems with being off of work or work restrictions which included but

was not limited to the possibility of depression and a lack of self-worth. X should continue care with X treating doctor in order to help X condition, minimize and correct as well as reduce muscle spasms, decrease joint adhesions, increase range of motion and decrease the perception of pain. X had been participating in a X. This program should be continued to improve X condition to aid in increasing physical function, improve pain coping skills, and help facilitate healing.

X was seen by X, DO on X for chronic persistent back, right buttock and right leg pain below the level of the knee associated with numbness, weakness, and tingling. X underwent X. Some X months later, a large, X was noted, as well as a swollen X was noted. X underwent surgical intervention with fair results. X still had persistent numbness, weakness, tingling down X right leg causing an antalgic limp and gait. X felt X had difficulty walking on a daily basis and this was getting worse. X pain was X. X subsequently went X. X pain continued at a moderate to severe grade. X urinalysis was X. X maintained a positive outlook as X CESD was X suggestive of mild reactive depression. X risk for opioid misuse was low. X GAD-7 score was X. X PMP was satisfactory. X described X pain as sharp / shooting in "sciatic area. '' X had undergone appropriate physical therapy and rehabilitative care to try and maintain muscle mass as X continued to lose weight with inactivity. Examination showed X was in moderate distress. X walked with an antalgic limp and gait. Moderate lumbar interspinous tenderness at X was noted. X had moderate sciatic notch tenderness. Toes were downgoing. No ankle clonus was elicited. There was moderate lumbar interspinous tenderness with a positive straight leg raising sign on the right at X degrees, contralateral at X degrees on the left. No sudomotor or vasomotor changes were noted. X had decreased X on the right. The assessment included classic post lumbar laminectomy pain syndrome with recurrent radiculopathy following work injury and failed surgical intervention and secondary myofascial pain syndrome with generalized deconditioning. X was

recommended in conjunction with neuropathic pain medicine, Vitamin D supplementation, daily walking and exercise therapy. X was added at night. X was recommended to X.

On X, Mr. Rice was seen by Dr. Atlin for X ongoing complaints. X continued with moderate-to-severe back, buttock and leg pain associated with lumbar radiculopathy. Over a year ago, X got a X. Unfortunately, the doctor did not do their due diligence. X reported more than X pain relief, improved function, and decreased use of medication. X had undergone X and that was recurrent. It was under the ODG guideline, the patients who do treatment, which ameliorated or relieved the natural compensable disease state supported in the Texas Labor Code, repeat injection therapy for recurrent radiculitis was indicated and would be re-recommended. In the meantime, X was suffering. The pain was rated X and they were trying a X. The Texas Medical Board supported intervention in lieu of the opioid epidemic. As a result, X would continue on X, which X stated did somewhat dampen the pain. X was still having right and left buttock pain often radiating below the level of the knee particularly on the right that day with a positive straight leg raising sign. X MRl was consistent with an X. X was recommended due to X anxiety, fear of needles, and X previous treatment requiring minimal sedation. Further delays in the treatment would only lead to more refractory and costly pain complaints. X was walking with an antalgic limp and X pain was rated as X. X was having difficulty sleeping. X was recommended to increase X.

An electromyography (EMG) / nerve conduction study (NCS) of the bilateral lower extremities dated X showed X. Normal motor NCS was noted of the right and left peroneal nerves. The right peroneal motor nerve conduction velocity was in the slow normal range. Normal sensory nerve conduction studies of the right and left sural nerves was noted. Normal right and left tibial nerve H reflex latencies to the soleus muscles

was noted. Lower back pain was noted. There was pain to palpation over the right iliolumbar area. Decreased right hip range of motion was noted. X-rays of the lumbar spine dated X revealed X. Lucency through the base of the X process was noted, which may indicate a X. X was noted at X. An MRI of the lumbar spine dated X showed a right sided X. There was also X. Contact of the X on the right was noted.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The Official Disability Guidelines recommend X. The procedure can be performed by X. X are only warranted with functional improvement of X or more for X weeks or longer. Procedure performed under fluoroscopic or CT guidance. Use of X is not recommended. A prior request X was non-certified in X on X as the request was not supported by the guidelines. The claimant received a X on X without documentation that warranted a X as indicated by the guidelines. Additionally, there was X. The request is not warranted at this time. The claimant complained of low back pain due to a fall. The claimant received a X. The Official Disability Guidelines recommend X. The procedure can be performed by X. X are only warranted with functional improvement of X or more for X weeks or longer. Procedure performed under fluoroscopic or CT guidance. The use of anesthesia or sedation is not recommended. A X is only warranted with documented improvement of X or more for X weeks or longer. There was no indication of the progress received from the X. For this reason, the prospective request for X is non-certified."

Per a reconsideration review adverse determination letter dated X by X, MD the request for X was denied. Rationale: "The prior determination will be upheld. The X report detailed X. However, on X electrodiagnostic test was X. Additionally, it is notable that the X report was X. As such,

there are only X. Additionally, the only available MRI dates from before the X. It must also be noted that X. No other clinical reporting has been submitted for review. Therefore, the appeal request for X is non-certified."

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Regarding X. X is warranted with X improvement in pain or function for at least X weeks, deterioration since X. They should be administered under fluoroscopy or CT guidance. The procedure should be performed X. The use of X is not recommended. Proceeding with an X is not warranted. This request was non-certified twice, with the non-certification being upheld in review X on X. While the request for minimal sedation was clarified, there was no indication that the X gave X pain improvement or improvement in function for at least X weeks. The electrodiagnostic study showed no X. The available MRI was taken prior to surgical intervention. There are no clear objective findings of X. Based on this, the prospective request for X is non-certified."

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

Patient with continued pain issues despite X. Given potentially radicular source of pain, the provider is requesting and X. However, per cited ODG criteria, at least X improvement in pain or function for at least X weeks needed with X. While patient may have had X improvement in pain, it is unclear for how long, thus X may not be indicated. Further, pathology from MRI is from prior to X. Recommend prospective request for 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 continued pain issues despite X. Given potentially radicular source of pain, the provider is requesting and X. However, per cited ODG criteria, at least X improvement in pain or function for at least X weeks needed with X. While patient may have had X improvement in pain, it is unclear for how long, thus X. Further, pathology from MRI is from X. Recommend prospective request for 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:

☐ 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)**