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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 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 injured when X was lifting a box of X. The diagnoses were low back pain, radiculopathy of lumbar region, other intervertebral disc displacement of lumbar region, and spinal stenosis of lumbar region with neurogenic claudication. On X, X, MD evaluated X for initial evaluation of X lumbar spine. X was initially injured at work on X, when X was X. Over the next several days X had a gradual onset of bilateral lower extremity radiculopathy, left greater than right, that had continued to bother X since that time. X did have a history of X. X related that X had done well postoperatively overall, with very intermittent low back pain if X had increased activity but had not had any recurrent lower extremity symptoms over the years. X stated that prior to X injury at work X was not experiencing any low back pain and certainly was not experiencing any lower extremity radiculopathy. X presented with continued low back pain which radiated down the posterior aspect of X lower extremities into X feet. X noted that X feet remained constantly numb and tingly, in the left greater than right, and stated X felt there was constantly something pushing against the ball of X left foot. X did note some subjective weakness of X lower extremities with standing, walking, and with stairs. X also noted loss of the ability to dorsiflex X feet bilaterally, left greater than right, since X injury. X subsequently walked with a marching gait to ensure that X did not trip over X toes from the new onset of drop foot X was experiencing. X symptoms were constant, but progressed through the day and affected X sleep. X symptoms were increased with bending, prolonged sitting, lifting, prolonged standing, and walking. They were mildly alleviated with activity modification and lying down. X had tried X. X had undergone greater than X weeks of X. X had undergone a trial of a X with Dr. X on X. X related that this helped with X back pain for several days but did not seem to significantly improve the numbness and tingling in X lower extremities. On examination, there was X. There was X. Strength was X in bilateral lower extremities with dorsiflexion; X in the left lower extremity with hip flexion, leg extension, and plantar flexion; X in the right lower extremity with hip flexion, leg extension, and plantar flexion. X-rays of the lumbar spine taken in office showed X. An MRI of lumbar spine

obtained at an outside facility dated X was reviewed revealing at X. No significant X was seen. At X. At X. At X, there was a X. No X seen. On X, X, PhD / X, PhD / X, X performed psychological pre-surgical evaluation for a lumbar fusion. The diagnosis was pain disorder with related psychological factors. X appeared motivated to receive the X. Further. X ability to understand the relative risks and benefits of surgery was good. and X appeared motivated to participate responsibly in postsurgical recovery behaviors. X denied a psychiatric history or ongoing psychiatric symptomology. Specifically, X denied symptoms associated with a mood disorder, anxiety disorder, somatic disorder, substance abuse disorder, or psychotic disorder. Thus, X did not present with significant psychiatric symptoms contraindicative of a surgery or procedure. X reported a history of and ongoing X. Given the research on the X. Based on X evaluation, X predicted prognostic category for the X was good. X psychiatric status should not negatively impact the surgery or procedure and X was cleared to go through the X procedure. On X, X, MD evaluated X for medication follow-up. X pain level was X. X was adhering to medication regimen. X reported no side effects. Lumbar spine examination revealed motor strength of X at left ankle dorsiflexion. There was tenderness to palpation at X. Straight leg raise test was X on the left. It was documented that X was seen by a surgeon who had recommended surgical intervention. X were refilled. An MRI of lumbar spine dated X revealed X. There was moderate narrowing of the left lateral recess at X. Correlate for left X. At X. At X. At X, there was X. It measured X. On X, X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Official Disability Guidelines recommend X. On X, the claimant presented with low back complaints. X had a gradual onset of X. X has tried X. X has undergone greater than X weeks of physical therapy without improvement in X pain nor improvement in X drop foot bilaterally. X has undergone a trial of a X on X. X reports that this helped with X back pain for several days but did not seem to significantly improve the numbness and tingling in X lower extremities. On X, the claimant presented with bilateral leg complaints. Pain level was X. Bilateral lower extremity examination showed X. X left calf appeared slightly smaller than X right. X has X. They have some X. Electrodiagnostic studies showed X. In this case, there is no documented psychological screening with confounding issues addressed, documenting the presence and/or absence of identified psychological barriers that are known to preclude post-operative recovery. The guidelines criteria are not met. As such, the

medical necessity has not been established for the Request for X." Per a reconsideration / utilization review adverse determination letter dated X, by X, MD, the reconsideration request for X is denied. Rationale: "Official Disability Guidelines (ODG). The requested X is not medically necessary. The submitted medical records do not demonstrate instability at X. The MRI report demonstrates impingement of the X. There is no significant foraminal stenosis at X. The most recent clinical note from the treating provider is from X. A rationale for the requested X is not provided. As such, the guidelines have not been met for multiple reasons. Therefore, the requested X is non-authorized. "The claimant presented with continuing complaints of lower back and radicular leg pain which had not improved with X. Review of X. The claimant did have a X. However, review of the claimant's imaging did not detail evidence of X. The current evidence based guidelines do not recommend X. Therefore, it is this reviewer's opinion that medical necessity has not been established for the proposed X. As such, the prior denials are upheld. 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 claimant presented with continuing complaints of lower back and radicular leg pain which had not improved with conservative treatment such as X. The claimant did have a X. However, review of the claimant's imaging did not detail evidence of spondylolisthesis at X. The current evidence based guidelines do not recommend X. Therefore, it is this reviewer's opinion that medical necessity has not been established for the proposed X. As such, the prior denials are upheld. 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**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**