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IRO Certificate No:

**Notice of Workers' Compensation Independent Review Decision**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
X

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**
X

**PATIENT CLINICAL HISTORY [SUMMARY]:** X

X had an injury on X when X was driving an 18-wheeler truck, the wheel blew out and roll over. The injured worker had been followed for a history of chronic lower back and leg pain bilaterally with associated numbness and tingling. The injured worker underwent arthrodesis anterior interbody technique at X, application of intervertebral cage at X, bone marrow aspiration of the X vertebral body, autograft for spine surgery and use of intraoperative fluoroscopy (X), s/p anterior cervical discectomy and fusion (ACDF) X (X).

On X the injured worker was evaluated for continued lower back and right leg pain with numbness and tingling. In the physical exam, the provider noted limited range of motion with weakness at the right gastroc 4/5.

The chiropractic notes dated X indicate that the injured worker complaints of stabbing pain in the low back. X also reports that X

right leg has been giving out and calf is tight. X reports neck pain. In the physical examination of lumbar spine, the provider noted tenderness during palpation, limited range of motion (ROM) measured at flexion 40 degrees and extension 20 degrees. Bilateral straight leg raise was positive for pain. The injured worker was diagnosed with sprain and intervertebral disc displacement of cervical and lumbar spine. Plan: X.

On X the worker's compensation work status report noted that the injured worker was recovering from cervical spine surgery and prevented X from working from X to X as working places X at risk for further injury.

On X the provider stated that the patient was complaining of increasing low back pain radiated to bilateral lower extremities, right side is greater than the left along the lateral thigh and calf, intermittently into the dorsum of the right foot. No recent history of trauma or accidents of falls. The provider noted concern for a recurrent disc herniation vs adjacent segment disc disease.

On X the provider indicates that the injured worker reported no change and continued to experience the pain.

In the appeal letter dated X, the provider indicated the X is necessary to rule out recurrent disc herniation vs adjacent level disease.

On X the provider received a denial letter indicating that the request for X is non-authorized as not medically necessary. X is appropriate when MRI cannot be performed or in addition to MRI. There is no indication that the injured worker has been evaluated with MRI of the lumbar spine post-operatively with non-diagnostic findings. There is no evidence of the presence of a red flag condition.

On X the provider requested for IRO review for the denial of X.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The ODG guidelines indicate X is appropriate when magnetic resonance imaging (MRI) cannot be performed or in addition to MRI.
This case involves a X who sustained a work-related injury on X. The injured worker underwent arthrodesis anterior interbody technique at X, application of intervertebral cage at X, bone marrow aspiration of the L5 vertebral body, autograft for spine surgery and use of intraoperative fluoroscopy (X), status post anterior cervical discectomy and fusion (ACDF) X (X). On X the provider stated that the injured worker continued to report lower back and right leg pain radiated to bilateral lower extremities, right side is greater than the left along the lateral thigh and calf, intermittently into the dorsum of the right foot. No recent history of trauma or accidents of falls. The provider is requesting for the coverage of X to rule out recurrent disc herniation vs adjacent level disease and evaluate low back symptomatology. According to the guidelines, X are indicated if magnetic resonance imaging (MRI) is unavailable, contraindicated, or inconclusive. There is no post-operative imaging submitted for review. There is no prior MRI studies that showed inconclusive results and there is no indication that the injured worker has contraindication to MRI to support the necessity of the request. Therefore, based on the cited guidelines the request for X is considered not medically necessary and the prior denial should be upheld.

**QUESTIONS:**

1) **Is the requested X medically necessary?**

**Answer:** No, the requested X is not medically necessary.

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**SOURCE OF REVIEW CRITERIA:**

- ☐ ACOEM – American College of Occupational & Environmental Medicine UM Knowledgebase
- ☐ 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
- ☒ ODG- Official Disability Guidelines & Treatment 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)

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld