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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 sustained an injury on X. At work while working as X, X was helping to lift a piece of furniture and felt immediate severe low back pain. The diagnoses included intervertebral disc disorders with radiculopathy, lumbosacral region; spondylolisthesis, lumbar region; and obesity. X was seen by X, MD on X for back pain. X received X on X and reported X had definitely gotten measurable relief greater than X(and even X) with that. X complained that X radicular pain in the right buttock / posterior thigh leg / foot had returned. X rated X pain X. X indicated X was working at full capacity despite having Imitation of X pounds. "They will fire me if I don't do everything they need me to do." X body mass index (BMI) was 44.47 kg/m². Lumbar spine examination revealed pain in both buttocks. Active lumbar flexion, extension, lateral bending, and rotation were impaired. X exhibited paraspinal muscle spasms. Manual muscle testing revealed X strength in all major muscle groups. X were noted over right X. X-rays of the lumbar spine on X were X. X-rays of the X. An MRI of the lumbar spine on X revealed X. Treatment to date included X. Per the peer review by X, MD on X, the request for X was upheld / non-certified. Rationale: “Per Official Disability Guidelines, Pain Chapter Online Version (Updated X), X, “Conditionally Recommended. Recommended as an option; may be a first-line or second-line option. ODG Criteria * X. ALL of the following are present (1) (2) (3) (4) (5): 0 Radicular pain, duration, of >= X weeks, and 1 or more of the following (3) (6): Procedure performed via interlaminar approach. Lumbar radiculopathy by history (eg. radiation of pain and numbness along the distribution of the affected spinal root), and ALL of the following; Diagnostic imaging (eg, CT scan, MRI) correlates with symptoms. Procedure performed via caudal interlaminar, or transforaminal approach. Thoracic radiculopathy by history (eg. radiation of pain and numbness along the distribution of the affected spinal root), and ALL of the following: Diagnostic imaging (eg. CT scan. MRI) correlates with symptoms, Procedure performed via interlaminar or transforaminal approach. 0 Failure to respond, to >=4 weeks of

conservative care, as indicated by ALL of the following (7) (8) (9) (10): Nonsteroidal anti-inflammatory drug (NSAID), or contraindication to NSAID use Physical therapy, or documentation of patient intolerance to physical therapy X, as indicated by ALL of the following (12): Documentation of sustained improvement of pain or function of>= 50%, as measured from baseline, for >=6 weeks after prior injection. Pain or deterioration in (unction since prior injection o Pain causes functional disability, o Patient hits had < 4 sessions in prior 12-month period, o Procedure performed under fluoroscopic or CT guidance, o No bleeding or clotting disorder. No local or systemic infection." In this case, the previous X. Moreover, no imaging reports were provided, for review. The request is not shown to be medically necessary. Thus, the request is not certified. "Per the peer review by X, MD on X, the request for X was upheld / non-certified. Rationale: ""ODG by MCG Pain (Last review/update date: X) X may be indicated when ALL of the following are present {1) (2) (3) (4)(5): Radicular pain, duration of 4 weeks, and 1 or more of the following (3) (6) : Diagnostic imaging (eg, CT scan, MRI) correlates with symptoms. Procedure performed via interlaminar or transforaminal approach Failure to respond to X weeks of conservative care, as indicated by ALL of the following (7) (8) (9) (10): Nonsteroidal anti-inflammatory drug (NSAJD), or contraindication to NSAID use Physical therapy, or documentation of patient intolerance to physical therapy" The previous utilization report non-certified the request for X. In this ease, the current physical examination report dated X indicates bilateral buttock pain and facet loading bilaterally in the lumbar spine. Noteworthy findings include positive paraspinal muscle spasm, intact muscle strength, (manual muscle testing five out of five for all major muscle groups), X in a right X, absence of atrophy or wasting, symmetric reflexes, and no pathological reflexes identified. However, the overall clinical presentation aligns with nonspecific low back pain without a significant radicular component. In accordance with established guidelines, X are not recommended for non-acute axial back pain lacking a radicular component. Given the absence of substantial radicular symptoms and the nature of the reported pain, the requested X is not deemed medically necessary for this clinical scenario. Therefore, the request for X is non-certified and upheld. "The requested X is not medically necessary. The submitted medical records indicate that the patient previously underwent a X providing X relief. However, the duration of relief was not at least X weeks in duration. In addition, the MRI report does not demonstrate definitive nerve root impingement. The clinical records do not

demonstrate substantial radicular symptoms. As such, the requested X is not medically necessary or supported by the medical records. No new information has been provided which would overturn the previous denial. 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 requested X is not medically necessary. The submitted medical records indicate that the patient previously underwent a X providing X relief. However, the duration of relief was not at least X weeks in duration. In addition, the MRI report does not demonstrate definitive nerve root impingement. The clinical records do not demonstrate substantial radicular symptoms. As such, the requested X is not medically necessary or supported by the medical records. No new information has been provided which would overturn the previous denial. 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

☐ 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

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

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

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL