po box 519
schertz, tx 78154
p: 800.292.3051
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IRO Certificate No: X

Notice of Workers' Compensation Independent Review Decision

X

Original Decision Date: X
Amended Decision Date: X

TX IRO Case #: X

Coverage Type:

☒ Workers' Compensation Health Care Network

☐ Workers' Compensation (non-network) if applicable, decision must include specific basis for divergence from TDI/DWC policies or guidelines

Type of Review:

☒ Preauthorization Review

☐ Concurrent Review

☐ Retrospective Review

Prevailing party (if applicable)

☐ Requestor

☒ Carrier

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
X
INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]: On X, magnetic resonance imaging (MRI) of the lumbar spine revealed X.

On X, the patient underwent X.

On X, the patient presented for follow-up regarding X. On examination, there was tenderness of the iliolumbar region and the gluteus maximus. Seated straight leg raising test positive. X had X on X and reported very minimal relief from the X

On X, the patient was assessed with work-related injury now with subacute severe and progressive low back pain with left lower extremity pain numbness and tingling, neurogenic claudication despite maximal conservative treatment. X was recommended.

On X, the patient was noted doing alright but notes X had some increased aggravation over the weekend due to going to an event in which X performed a lot of walking and activity on X feet. Patient reported that X had to take a break the rest

of the day and sometime over the weekend. Patient denied adverse effects from last session. Patient continues to do X but notes that X does not yet perform at the correct volume. The patient has had a total of X.

On X, MRI of lumbar spine showed X. X changes are noted with decompression of the X. There was X. Posterior annular fissure. No thecal stenosis. Mild bilateral foraminal stenosis with osteophytes approximating the exiting X. Mild-to-moderate bilateral facet joint arthrosis. 2. X. Moderate bilateral facet joint arthrosis. There was interval increase in the X. Ligamentum flavum buckling. 3. X.

On X, the patient returned for MRI follow-up of X lower back. X was roughly X. X lower back had been bothering X since X after X sustained a work-related injury. During X last visit on X X returned noting that since X last visit on X X had continued to have severe low back pain with continued occasional radiation down X left leg. X noted that X can't walk more than 100 feet before X has to stop due to the X pain returning. X was occasionally taking X X. X notes today X symptoms remain essentially unchanged.

X, the request for X was denied.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS

USED TO SUPPORT THE DECISION: According to the Official Disability Guideline, **X**.

This X was assessed with X. On X, the patient underwent X. On X, the patient presented for follow-up regarding X. On examination, there was tenderness of the iliolumbar region and the gluteus maximus. Seated straight leg raising tests X. X had X on X and reported very minimal relief from the X and the pain has returned to the degree it was before. On X, the patient was noted doing alright but notes X had some increased aggravation over the weekend due to going to an event in which X performed a lot of walking and activity on X feet. Patient continues to do X and notes that X does it but not yet at the correct volume. On X, the patient returned for MRI follow-up on X lower back. X has a roughly X month status post a X on X for X. X lower back had been bothering X since X after X sustained a work-related injury. X returned noting that since X last visit on X X had continued to have severe lower back pain with continued occasional radiation down X left leg. X noted that X can't walk more than X feet before X has to stop due to the X pain returning. X was occasionally taking X X and has continued in X. X notes today X symptoms remain essentially unchanged.

Based on the review of the medical records, current literature, and guidelines used. The patient has failed to meet the recommended criteria for the proposed procedure. Documentation showed no evidence of radiculopathy. These

factors would indicate the need for X. Therefore, the request for X is not medically necessary.

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 (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part

ATTESTATIONS:

- X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X