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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 was injured on X. The mechanism of injury was fall at work. The diagnosis was spondylolisthesis of the lumbar region, fatigue fracture of vertebra at the lumbar region, other spondylosis with radiculopathy of the lumbar region, and connective tissue and disc stenosis of intervertebral foramina of lumbar region.

X was seen by X, MD in an office visit on X, for follow-up on low back pain and lumbar radiculopathy. X presented for "back pain." X denied a history of similar pain problems. X pain condition was the result of an on-the-job injury and was the result of a fall. At the time, X was experiencing pain in the right lumbar, left lumbar, and rated the percent distribution of the pain as X back and X leg. The pain was described as shooting, throbbing, tingling, stabbing, and sharp. The pain was rated at X and getting worse. X states the pain began around X. It was chronic and X described the onset of pain as: "After my fall at work." Symptoms were exacerbated by all activity and seemed to improve with sitting. The pain radiated bilaterally to the lower extremities, and the leg pain was rated at a X. Additionally, X had muscle weakness associated with pain, located in the right lumbar and left lumbar region, rated as moderate. X was reported in the X. Associated Symptoms included clicking / catching, and stiffness in the affected area. Cane / crutch support was needed when walking. X could sit less than X hour, stand less than X minutes, and was unable to walk comfortably at all. X activity level was described as mildly active at the time. Lumbar examination revealed X. X ambulated with X. X-rays of the lumbar spine obtained on X, identified

evidence of prior complete X. CT scan of the lumbar spine from X was reviewed and identified X. There was X. The diagnosis was spondylolisthesis of the lumbar region, fatigue fracture of vertebra at the lumbar region, other spondylosis with radiculopathy of the lumbar region, and connective tissue and disc stenosis of intervertebral foramina of lumbar region. Dr. X wrote that X pain was constant, debilitating, and affected X activities of daily living including standing and walking tolerance. X now must use a X. X noted X stopped smoking over X months ago. X had tried greater than X weeks of X. As X had X, Dr. X discussed surgical intervention. Surgery would likely entail X. X was in agreement with plan. Dr. X prescribed a X. X believed the X was critical to X care, medically necessary, and provided an additional treatment modality. X was at increased risk for X. Dr. X highly recommended X be fitted with an X. Dr. X believed this X.

X-rays of the lumbar spine obtained on X, identified evidence of prior X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X: “The request is not medically necessary. The records did not detail failure of non-operative measures as recent prescription medications for pain were not detailed. There were no current physical therapy records included for review. The claimant's imaging noted a X. There is no evidence of X. There are X noted. There was X. Further, the claimant was noted to be a X. The claimant was also recommended for X. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request. Therefore, the request for X is not medically necessary.” Rationale for denial of the request for a X: “The request is not medically necessary. The requested procedure is non-certified; hence, the request is not

medically necessary. Therefore, the request for a X is not medically necessary." Rationale for denial of the request for an X: "The request is not medically necessary. The requested procedure is non-certified; hence, the request is not medically necessary. Therefore, the request for an X is not medically necessary." Rationale for denial of the request for X: "The request is not medically necessary. The requested procedure is non-certified, hence, the request is not medically necessary. Therefore, the request for an X is not medically necessary."

A letter dated X, by X, MD, documented: "This is a letter appealing the decision to X. The patient has history of work X For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031. X injury, which subsequently caused a X. X has active motion at X. X noted on CT scan. X has X. X has X. I have indicated patient for X. X has been compliant with non-smoking for greater than X months and has no other concerning co-morbidities which would limit this procedure from being effective. I recommend X. Please be aware during prior peer to peer, surgery was reportedly going to be approved if CT scan showed X, which is does."

Per a reconsideration review adverse determination letter dated X, by X, MD, the appeal request for surgery for X was denied. Rationale for denial of request for X: "The request is not medically necessary. The claimant has X. This is an indication for X based on ODG. Prior denial occurred for lack of smoking cessation documentation. Dr. X confirmed that the claimant had ceased smoking for X months. We also discussed high BMI and Dr. X noted that the claimant had been in a self-directed weight loss program and decreased X BMI to X. However, a review of documentation shows that a more recent exam (X) shows no exam findings consistent with radiculopathy and there is a discrepancy

between the claimant's documented smoking status and the conversation in which Dr. X indicated X months of smoking cessation. As such, the request is not supported. Therefore, the request for X is not medically necessary." Rationale for denial of the request for X: "The request is not medically necessary. Surgery does not meet ODG." Rationale for denial of the request for X: "The request is not medically necessary. Surgery does not meet ODG." Rationale for denial of the request for X: "The request is not medically necessary. Surgery does not meet ODG."

The requested surgical procedure is not medically necessary. The submitted documentation indicates the patient has a BMI of X. There is no documentation that the patient has had a reduction in weight. There appears to be discrepancy in the patient's nicotine status. The records do not reflect dynamic instability at X. The submitted records do not indicate the presence of symptomatic radiculopathy. As such, the guidelines have not been met for the requested procedure. No new information has been provided which would overturn the previous denials. 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 surgical procedure is not medically necessary. The submitted documentation indicates the patient has a BMI of X. There is no documentation that the patient has had a reduction in weight. There appears to be discrepancy in the patient's nicotine status. The records do not reflect dynamic instability at X. The submitted records do not indicate the presence of symptomatic radiculopathy. As such, the guidelines have not been met for the requested procedure. No new information has been provided which would overturn the previous

denials. 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:

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

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

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE