Core 400 LLC

Notice of Independent Review Decision

Core 400 LLC
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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 at work on X when X fell backwards approximately X feet in the air and landed on X low back and head. The diagnoses were vertebrogenic low back pain; intervertebral disc stenosis of neural canal of lumbar region; other spondylosis with radiculopathy, lumbar region; spondylolisthesis, lumbosacral region; and other intervertebral disc displacement, lumbosacral region On X, X was seen by X, MD, for follow-up of low back pain. X presented with low back pain that had been ongoing since X. X worked as a X. At that time, X was at work, when X fell backwards approximately X feet in the air and landed on X low back and head. X reported X sustained a concussion and neck injury as well as injury to X low back. X denied loss of consciousness. X reported X was told X had a lumbar fracture and "compressed vertebra in the neck." X reported that X had a CT scan of X lumbar spine that revealed an X. X denied any loss of bowel or bladder. X had been X. X did return to full duty as a X. X reported increasing low back pain with bilateral lower extremity radicular symptoms into the plantar aspect of bilateral feet, greater in the right leg. Overall, the low back pain was greater than the right lower extremity symptoms. X reported increasing symptoms with walking but worse with sitting. Standing in a stationary position had improved X symptoms. X had been taking X. X had difficulty in sitting secondary to the pain. X returned to the office at the time, following repeated X. X reported feeling zero (X)% better following the X. When X was standing and walking, X did okay, but when X started to sit for any length of time, X had increased pain in the low back radiating down the right lower extremity. At the time, this pain was increasing again down the right lower extremity and was worse with sitting and physical activity. The pain was radiating in the X. X rated the pain as an X. Physical examination revealed X was well-nourished, well-developed. X was unable to sit in a normal position and was changing X positions frequently during the exam due to pain. X did appear to be in mild to moderate distress secondary to pain on the day during exam. X had an X.

There was X. Lumbar flexion was to the level of the knees, extension to neutral. Examination of the bilateral lower extremities revealed X was able localize sensation of light touch in the X. There was X strength in the X. X had normal reflexive patellar reflexes with diminished Achilles reflexes bilaterally. Straight leg raise and contralateral straight leg raise reproduced pain in the X. An MRI of the lumbar spine was reviewed and revealed a X. There was X. At the X. X-rays of the lumbar spine obtained on X, revealed X. There was X. X were noted at X. Dr. X assessed that X presented with X. X had a X. X fracture was stable. X reported continued X. X symptoms continued to progress and significantly interfered with X activities of daily living. X had X. Surgical options were discussed which would include an X. X had X. Dr. X believed this would best be addressed with an X. An MRI of the lumbar spine dated X demonstrated, at the X, there was no evidence for X noted. At the X. X was noted. At the X. Moderate X was noted. There was X. X was present with X. At the X. X-rays of the lumbar spine obtained on X, revealed X. There was X. X were noted at 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: “ODG states that X. For X there should be evidence of a X. X is not recommended for X. In this case, review of the records shows only mild X in the imaging provided. There is no imaging evidence of X. Current evidence-based guidelines do not support the performance X. Therefore, X is not medically necessary.” Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: “ODG states that X. For X there should be evidence of a X. X is not recommended for X. In this case, the provider notes that the claimant has X. However, there is X. There is no imaging evidence of X. Furthermore, the guidelines do not support X. Therefore, the requested X is not medically necessary.” Based on the submitted documentation, the requested surgical procedure is not medically necessary. The submitted imaging reports do not demonstrate significant X. The records do not reflect the presence of instability at the operative level. There is no indication by the treating provider of iatrogenic instability. Thus, the requested server procedure is not medically necessary. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified

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

Based on the submitted documentation, the requested surgical procedure is not medically necessary. The submitted imaging reports do not demonstrate significant X. The records do not reflect the presence of instability at the operative level. There is no indication by the treating provider of X. Thus, the requested server procedure is not medically necessary. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified
Upheld

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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)**