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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 at work on X. X was working, X. X slipped on X. The diagnoses were (X) spondylolisthesis, site unspecified; and (X) radiculopathy, lumbar region.

On X, X was seen by X, MD, for evaluation of chief complaint of lower back pain. X presented for evaluation post MRI. X had X. X did have some X. At the time, they were discussing options for further management with underlying nerve complaints, more on the right side than the left, and back complaints. On examination, blood pressure was X mmHg. The right tibialis anterior strength was X and left tibialis anterior strength was X. The right extensor hallucis longus (EHL)/peroneus strength was X. The right ankle, right/left knee reflexes were hypo. Light touch was abnormal in the right X. An x-ray was performed in the office that day and revealed X. Most dramatic was a translation compared to supine MRI. An MRI of the lumbar spine was reviewed and revealed X. Dr. X assessed X. X fit the criteria for X. X spondylolisthesis measured about X. Dr. X noted that at that time, the data was very clear regarding intervention from a surgical standpoint for X. There was definitely an indication for a X. In the interval, to remediate some of the nerve pain, it was reasonable to consider X. the diagnoses were essential X.

Review of an MRI of the lumbar spine by Dr. X on X, revealed X. On X, an x-ray was performed in the office and revealed X. Most dramatic was a translation compared to X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: “The Official Disability Guidelines recommend X. Also, the use of X is not recommended. In this case, the claimant has lower back pain, right more than left, that radiates to the right X. MRI revealed X. Previous treatments include X. As per notes, the provider also billed for the use of X. The provider has planned to proceed with X. However, the request is not supported as there was no documentation that the pain is causing significant functional disability. Additionally, the provider will perform the procedure under X which is not recommended by the guidelines due to the need for potential patient reports of symptoms during the procedure. As such, the medical necessity has not been established for X.”

Per a reconsideration review adverse determination letter dated X, by X, MD, the request for X was denied as not medically necessary. Rationale: “Per ODG, “ODG X. Procedure performed X.” The requested X is not medically necessary or appropriate. The MRI report does not demonstrate X. Thus, the guidelines have not been met. The requested X is non-authorized.

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: “The Official Disability Guidelines recommend X. Also, the use of X, X, or X care is not recommended. In this case, the claimant has lower back pain, right more than left, that radiates to the right tibialis anterior region causing unilateral weakness. MRI revealed X. Previous treatments include X. As per notes, the provider also billed for the use of X. The provider has planned to proceed with X. However, the request is not supported as

there was no documentation that the pain is causing significant functional disability. Additionally, the provider will perform the procedure X which is not recommended by the guidelines due to the need for potential patient reports of symptoms during the procedure. As such, the medical necessity has not been established for X." Per a reconsideration review adverse determination letter dated X, by X, MD, the request for X was denied as not medically necessary. Rationale: "Per ODG, "ODG Criteria X. Procedure performed via X." The requested X is not medically necessary or appropriate. The MRI report does not demonstrate X. Thus, the guidelines have not been met. The requested X is non-authorized. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no documentation of recent or ongoing active treatment modalities. Prior X was in X. There are no official diagnostic study reports submitted for review. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. 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:

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: "The Official Disability Guidelines recommend X. Also, the use of X care is not recommended. In this case, the claimant has lower back pain, right more than left, that radiates to the right tibialis anterior region causing unilateral weakness. MRI revealed X. Previous treatments include X. As per notes, the provider also billed for the use of X. The provider has planned to proceed with X. However, the request is not supported as there was no

documentation that the pain is causing significant functional disability. Additionally, the provider will perform the procedure under X. As such, the medical necessity has not been established for X." Per a reconsideration review adverse determination letter dated X, by X, MD, the request for X was denied as not medically necessary. Rationale: "Per ODG, "ODG Criteria X." The requested X is not medically necessary or appropriate. The MRI report does not X. Thus, the guidelines have not been met. The requested X is non-authorized. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no documentation of recent or ongoing active treatment modalities. Prior X was in X. There are no official diagnostic study reports submitted for review. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. 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