

Notice of Independent Review Decision

IRO Case number:

Description of the services in dispute

X

Description of the qualifications for each physician or health care provider who reviewed the decision

The professionally certified health care provider is board-certified in X

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)

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

The claimant is a X diagnosed with other intervertebral disc displacement lumbar region (X), chronic pain syndrome (X), and other spondylosis lumbar

region (X). This review is to determine the medical necessity of prospective request for X.

The Letter of Medical Necessity by X dated X stated that the claimant had tried radiofrequency in the past and did not want to consider this treatment at this time. X would like to try X for X flare-up of axial back pain. ODG Guidelines do not support X. The document further stated that, "Previous treatments included X. They had a X on X with 80% relief. An x-ray of the lumbar spine on X was ordered with pending results. According to the progress report submitted by X., dated X, the claimant presented with worsened back pain that occurs frequently. The severity level was 7/10 and located at the lower back. The pain radiated to the hip/thigh. They described the pain as aching, dull, stabbing, and throbbing. The pain was aggravated by ascending stairs and daily activities. Descending stairs, flexion, extension, standing, twisting, and walking. The claimant reported they cannot get flare-ups in pain settled down with medications. Upon examination of the lumbar spine, it was noted that the pelvis was unlevel on the left lower side. Moderate muscle spasms were present, along with tenderness in the facets at the L3-S1 levels and in the paraspinal region, quadratus lumborum, iliocostalis lumborum, and iliopsoas insertion sites. Both the right and left buttocks are painful. The lumbar range of motion showed moderate pain and restriction in flexion, extension, and lateral bending. The provider is appealing the prior determination at this time. Regarding X, the Official Disability Guidelines recommend that a X confirms the facet joint is the source of spinal pain. The claimant is a candidate for facet neurotomy, indicated by chronic spinal pain and failure of at least three months of non-operative management such as exercise, medication, and physical therapy. Imaging studies and physical examination have ruled out other causes of spinal pain."

The Rhizotomy Facet Nerve – Lumbar by X dated X stated that the claimant received X. X tolerated the procedure well and was discharged in stable condition.

The Office Visit by X dated X stated that the claimant had a total of 70% pain reduction from the previous X. The claimant presented to the clinic complaining of persistent lower back pain. X rated the pain as a 5/10 at this visit.

The Office Visit by X dated X stated that the claimant is currently doing X and is taking medications for X pain. X is on X every six hours as needed. Physical examination findings pertaining to X back include, "Gait: normal. Posture: pelvis unlevel, left lower. Muscle tone lower extremity: lower extremity muscle tone is normal. Muscle tone paraspinal: paraspinous tone is normal. Spasm: moderate. Tenderness: facet tenderness L3-S1, paraspinous, quadratus, iliocostalis lumborum, iliopsoas insertion. Buttock - Right: Painful. Left: Painful. Sacroiliac joint: Right: Painless. Left: Painless. Straight leg raise - Right: normal, Left: normal. Motor 5/5 strength BLE. Skin/scars: Normal. Patrick's (Faber) - Right: Negative. Left: Negative. Pain: moderate pain. Restriction: flexion moderate restriction, extension moderate restriction, lateral bending moderate restriction."

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

The claimant is a X diagnosed with other intervertebral disc displacement lumbar region (X), chronic pain syndrome (X), and other spondylosis lumbar region (X). This review is to determine the medical necessity of X.

The claimant has attempted an adequate trial of nonsurgical management, and the examination does demonstrate facet tenderness in the L3-S1 levels which would warrant the procedure recommended. Additional conservative management is not appropriate or necessary in this setting. The claimant

has evidence of facet mediated pain and failed multimodal nonsurgical management, and this would be considered the likely cause of the claimant's symptoms. Therefore, the X that were recommended are considered medically necessary.

ODG Guidelines for X do not indicate the use of X for lumbar spine pain. The reviewer disagrees with these guidelines as other conservative treatments have been tried and failed. Furthermore, the medical literature is more specific to the claimant's condition than the ODG Guidelines.

Therefore, it is the professional opinion of the medical reviewer to overturn the decision to deny a prospective request for X due to medical necessity of the request.

Description and source of the screening criteria or other clinical basis used to make the decision

- ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase
- AHRQ - Agency for Healthcare Research and 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)