



Physio Solutions LLC
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Notice of Independent Review Decision

Description of the services in dispute:

X

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

A physician reviewer, 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.

X

Information provided to the IRO for review

X

Patient clinical history

X, date of birth X, is a X old individual diagnosed with chronic back pain syndrome with lumbar disc protrusion at L4-5 and left lumbar radiculitis and seeking coverage for X.

The claimant's date of injury is X. X was lifting heavy cases and noted a sudden pop in X back. MRI lumbar spine dated X shows at L4-5 disc desiccation is appreciated. There is a broad 2-4 mm disc protrusion most pronounced on the left posterior lateral area with moderate left and mild to moderate right neural foraminal narrowing. There is borderline thecal sac stenosis. Initial pain evaluation dated X indicates straight leg raising is positive at 60 degrees on the left. X has decreased pinprick in the L5 distribution. Office visit note dated X by Dr. X indicates that the claimant continues with moderate to severe axial back, buttock, and left leg pain below the level of the knee. X has exhausted physical therapy and rehabilitative medical treatment options. X walks with an antalgic limp. Pain is 8/10. X has moderate left sciatic notch tenderness with positive straight leg raising. The claimant is on X and feels some relief. X is expressing anxiety and fear and will require minimal sedation to provide a safe surgical field. Prior request for X was non-certified noting that, "In this case, the claimant reported radicular low back pain with failed physical therapy and potentially concordant lumbar spine MRI findings. However, the X is planned with X. Although a plan for X is documented, the requested CPT code corresponds to X, which is excessive and unnecessary for X. ODG guidelines do not recommend X. Therefore, the request for X is not medically necessary." The denial was upheld on appeal noting, "in this case, per the recent visit, the claimant endorsed moderate to severe axial back pain. They had moderate left sciatic notch tenderness with a positive straight leg raising sign. They had failed physical therapy and rehabilitative medical treatment options. An MRI of the lumbar spine dated X demonstrated discogenic changes with bulges and protrusions throughout the lumbar spine at each level. Despite these findings, medical necessity for X cannot be determined as the guidelines do not support the use of X. As such, the request for Appeal request for X is not medically necessary."

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

Based on the clinical information provided, the request for X is medically necessary, and the denial is overturned. The Official Disability Guidelines support the use of X to treat lumbar radiculopathy. The submitted clinical records indicate that the claimant presents with radicular findings on physical examination corroborated by imaging. MRI lumbar spine dated X shows at L4-5 disc desiccation is appreciated. There is a broad 2-4 mm disc protrusion most pronounced on the left posterior lateral area with moderate left and mild to moderate right neural foraminal narrowing. There is borderline thecal sac stenosis. Initial pain evaluation dated X indicates straight leg raising is positive at 60 degrees on the left. X has decreased pinprick in the L5 distribution. X has exhausted lower levels of care including X. X is expressing anxiety and fear and will require X. As such, X is medically necessary.

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)