True Resolutions Inc.

Notice of Independent Review Decision

True Resolutions Inc.
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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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X. X sustained a work related injury X when an 18-wheeler driver hit the work vehicle (18-wheeler) at full speed. The diagnosis was lumbar spinal stenosis with neurogenic claudication, lumbar and cervical radiculopathy, and traumatic rupture of lumbar and cervical intervertebral discs.

On X, X was seen by X, MD for follow-up of severe back pain with left leg pain and neurogenic claudication and severe neck pain with arm pain and hand numbness. X endorsed persistent symptoms since X prior visit. The back pain was dull, sharp, and achy, which caused discomfort. It was severe in quality. There was radiation pain in the bilateral hips and buttocks and down to the left leg and feet. This was associated with constant numbness, tingling, and pins and needle sensation. The aggravating activities included bending, arching, twisting, and lateral flexion. There was only a slight reduction with the use of medication and position changes. X got minimal relief from resting. Conservative treatment included over-the-counter medication, which did not produce a significant change in symptoms. on examination, strength was noted to be 4/5 in the left “Q KF / H DF / AT PF / G EHL.” There was decreased sensation to pinprick in the feet and left hand. X gait was antalgic. Limited spine range of motion (ROM) and tenderness to palpation in the lumbar and cervical spine were noted. Kemp test, Spurling’s test, and Compression test were positive. Straight leg raising (SLR) test was “positive” in the bilateral legs. Review of MRI of the lumbar spine dated X showed a chronic, broad based posterior 4. 7 mm subligamentous disc herniation with cranial migration and several disc bulges from L2-L5. At L5-S1, a chronic broad-based left subarticular / foraminal 5.1 mm disc herniation was identified. There was posterior displacement and flattening deformity of the descending left S1 nerve root. Moderate left foraminal stenosis was present. Review of x-rays of the lumbar spine dated X was negative for fracture and dislocation. Considering the

examination, imaging findings, and ongoing symptoms, it was opined that he would benefit from an X.
On X, X, MD evaluated X for neck and back pain. X had severe back pain that radiated to the left leg. In the prior visit, X had unstable walk and pain with ambulation. Examination remained unchanged from the prior visit.

An EMG / NCV study of the bilateral lower extremities dated X showed evidence of left L5-S1 radiculopathy with mild active denervation.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: “Per Official Disability Guidelines, X is recommended for lumbar radiculopathy by history. In this case, the claimant complained of lumbar spine pain. X had minimal relief from resting. Conservative treatment included over-the-counter medication, which did not produce a significant change in symptoms. There was limited range of motion. There was positive Kemp’s test, Spurling’s test, and Compression test. Straight leg raise was positive bilaterally. Review of MRI of lumbar spine dated X revealed a chronic, broad based posterior 4.7 mm subligamentous disc herniation with cranial migration. There were several disc bulges from L2-L5. At L5-S1, a chronic broad-based left subarticular I foraminal 5.1 mm disc herniation was identified. There was posterior displacement and flattening deformity of the descending left S1 nerve root and moderate left foraminal stenosis. EMG and NCV are yet to be performed for confirmation of radiculopathy. As such, the request for X is not medically necessary.”

Per a reconsideration review adverse determination letter dated X by X, MD, appeal for X was denied. Rationale: “The Official Disability Guidelines support X for complaints of radicular pain that have not improved with first-line conservative treatment. There should be corresponding objective findings on physical examination and MRI. Repeat X are supported if there is at least 50% pain relief for at least six weeks from X. In this case, progress notes include complaints

of back pain and numbness and tingling in the left lower extremity. MRI reveals displacement of the left-sided S1 nerve root. However, the physical examination on X, does not include any abnormal neurological findings to correlate with the subjective complaints and imaging study results. Absent these objective findings, the request for X, is not medically necessary."

Thoroughly reviewed provided records including provider notes, imaging findings, EMG/NCS interpretations, as well as peer reviews.

The patient has pain in radicular distribution that has continued despite conservative treatment. Given corresponding MRI findings, as well as supplementation with EMG/NCS, the request for X is warranted. X is medically necessary and certified

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Thoroughly reviewed provided records including provider notes, imaging findings, EMG/NCS interpretations, as well as peer reviews.

The patient has pain in radicular distribution that has continued despite conservative treatment. Given corresponding MRI findings, as well as supplementation with EMG/NCS, the request for X is medically necessary and certified

Overturned

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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