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Notice of Independent Review Decision

Sent to the Following

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 on X. The mechanism of injury was described as a X. The diagnosis was radiculopathy of the lumbosacral region; spinal stenosis, lumbar region with neurogenic claudication; traumatic rupture of lumbar intervertebral disc, initial encounter.

On X was seen by X, MD, for low back pain and left leg pain. The pain began immediately after a X. The back pain was dull, sharp, and caused discomfort. It was rated moderate to severe. There was radiation pain in the left leg. This was associated with tingling in the thighs but not the feet. Aggravating activities included bending, lifting, and twisting. There was only a slight reduction with the use of X. X got minimal relief with X. Conservative treatment includes X, which did not produce a significant change in symptoms. X denied loss of dexterity, weakness, or balance issues. Examination noted a body mass index (BMI) of 35.16 kg/m2. There was decreased sensation to X. An X was seen. The spine revealed X. Kemp test, Spurling test, and compression test were X. Straight leg raise (SLR) test left was X? The assessment was X. It was noted that X complained of back pain with radiation to the legs and feet, in association with foot numbness. MRI of the lumbar spine without contrast showed X. On physical exam, there was back tenderness, limited range of motion, decreased left foot sensation, and SLR test (+) on the left. The radicular component persisted. These findings correlated with X ongoing symptoms. Considering the exam and ongoing symptoms, X would benefit from an X. A X was given in the office for pain relief. Dr. X

noted that given the complexity of X condition and to ensure both X comfort and the best possible outcome, conscious sedation was medically necessary (X). Many patients experienced significant discomfort and anxiety during X. X helped facilitate a safer, more effective, and well-tolerated procedure. Dr. X further noted, “Considering the mechanics of trauma, it is under medical probability that these symptoms result from the injuries received during the accident. The patient denied any pain before the injury.” The ongoing X was continued. X was given for pain relief and was tolerated well without complications.

Per a letter dated X, Dr. X wrote, “I am writing to appeal the denial of authorization for X for my patient, who presents with persistent low back pain and associated left leg symptoms. The patient's symptoms began immediately following a X. The lumbar pain is described as dull and sharp, rated moderate to severe, with radiation into the left leg and associated tingling in the thigh. Aggravating factors include bending, lifting, and twisting. Medications, including X, provide only minimal relief. The patient has undergone an adequate course of X. On follow-up examinations (X and X), the patient continued to report worsening back and leg pain, limited range of motion, and weakness in the left leg. Given the persistence and progression of symptoms despite X, as well as the functional impairment caused by pain and weakness, a X is medically necessary. This procedure is appropriate for: X

The requested procedure is consistent with evidence-based guidelines for patients with X. I respectfully request reconsideration and approval of the requested X to address the patient's ongoing, function-limiting lumbar pain and radicular symptoms. Given the complexity of the patient's condition and to ensure both X comfort and the best possible outcome, X is medically necessary (X). Many patients experience significant discomfort and anxiety during X. X helps facilitate a safer,

more effective, and well-tolerated procedure."

An X, revealed X. An MRI of the lumbar spine dated X, demonstrated X. There was X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X, was denied by X, MD, as not appropriate or medically necessary. Rationale: "The Official Disability Guidelines recommend X for radicular pain by history, imaging that correlates with symptoms, and failure of conservative care. Use of X. The Official Disability Guidelines recommend X with documentation pf sustained improvement of pain or function of at least X, as measured from baseline, for at least X weeks after X. The claimant is complaining of chronic back pain radiating to the left leg showed decreased X at left foot, X, limited X, X straight leg raise test on the left. MRI reviewed X. The claimant has X according to behavioral health notes. The physician noted that the claimant may experience X. Based on the reports submitted, it has been more than a X since the claimant's last X. However, there was no documentation of objective functional improvements and comparison of pain scale for a duration of at least X. Thus, the request for X is noncertified."

Per a utilization review adverse determination letter dated X, the request for X, was denied by X, DO, as not appropriate or medically necessary. Rationale: "The Official Disability Guidelines recommend X with documentation of sustained improvement of pain or function of at least X, as measured from baseline, for at least X weeks after X. While use of X. The claimant is complaining of chronic back pain radiating to lower extremity. The assessment includes X. The claimant had X. The physician recommended X. This request was previously noncertified due to no objective functional improvements and comparison of pain scale from X.

The physician sent a letter of medical necessity stating that the claimant has been working radiating to the left leg associated with tingling in the thigh. The claimant has undergone adequate course of X. Due to functional impairment, X was recommended. For comfort and best possible outcome, X was recommended as well. However, the original review noted that this is a X as the claimant had a X. But the result of X is still not indicated. Also, comfort is not a medical reason for X. Thus, the request for X is noncertified."

Per a prior authorization request letter dated X, "This is Dr. X recommendation: X. Given the complexity of the patient's condition and to ensure both X comfort and the best possible outcome, X is medically necessary (X). Many patients experience significant discomfort and anxiety during X. X helps facilitate a safer, more effective, and well-tolerated procedure."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "The proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines recommend X. The guidelines do not recommend use of X. In this case, the claimant is X with complaints of moderate to severe low back pain radiating to the left leg associated with tingling in the thighs. Decreased X to the left foot, X, limited X were noted. X showed no evidence of a X. MRI showed X. Prior treatments include X. The treating provider recommends X. X is requested to facilitate a safer, more effective and well tolerated procedure. However, measurable functional improvement from X was not provided. The records did not identify that the claimant had X. In addition, the guidelines do not recommend use of X. As such, the request for X is non-certified."

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

Based on the submitted documentation, the guidelines do not recommend use of X. In this case, the claimant is X with complaints of moderate to severe low back pain radiating to the left leg associated with tingling in the thighs. Decreased X to the left foot, X, limited X were noted. X showed X. MRI showed X. The records do not clearly demonstrate X. No new information has been provided to overturn the previous denials. X is not medically necessary and non-certified.

Non-Certified.

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)**