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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 on X. X sustained lower back injury with pain that X. The diagnoses were chronic pain syndrome, rupture of lumbar intervertebral disc / other intervertebral disc displacement, lumbar region (X), history of procedure / other specified post-procedural states (X), and other specified injuries of lower back, initial

encounter (X).

On X, X was seen by X, PA-C / X, MD for follow-up on Workers' Compensation (WC) injury for assessment of chronic pain, medication evaluation, and refills. X had been referred here for evaluation and treatment of pain that was located in the low back with radiation to the left leg primarily anteriorly and laterally with some associated numbness; the pain and numbness seem to be primarily in the X. The pain initially started in X after a work-related injury due to X. After the fall in X, X had subsequent back surgery in X, but continued to have pain. X was treated by Dr. X with X that did help, but subsequently had to find a new doctor due to Dr. X retirement. The pain was interfering with X quality of life, decreasing daily living activities. X reported the lower back pain was rated between X and X in intensity, worsened by the cold weather, and it radiated down the left leg , with occasional discomfort in the right leg.  Both X knees were also hurting. X reported experiencing significant relief from an X received in X, but expressed uncertainty about insurance coverage for another X. X needed X. The ongoing pain medications were moderately effective in treating the pain. X vital signs were stable. Examination revealed X. X had a flat affect. Lumbar / lumbosacral spine and sacroiliac joint examination revealed X. Left knee demonstrated decreased range of motion. The assessment was X. X were refilled; order was placed for scheduling X.

An MRI of the lumbar spine dated X demonstrated X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD noting "A review for medical necessity and appropriateness of the requested service(s) listed below has been conducted on behalf of X. The requested service(s) or treatment(s) are not medically necessary or appropriate and are therefore not approved." Rationale: "ODG notes X may be indicated when there is radicular pain with a duration of X weeks and lumbar radiculopathy by history (e.g., radiation of pain and numbness along the distribution of the affected spinal root), and diagnostic imaging (e.g., CT scan, MRI) correlates with symptoms. The procedure must be performed X. X is clinically appropriate in patients with good response to X, as indicated by documentation of sustained improvement of pain or function of X percent, as measured from baseline, for X weeks after X There must be pain or

deterioration in function since X. In this case, records show the claimant is X on X. There is no documentation of sustained pain relief or function improvement for a minimum of X weeks with the previous X supporting a repeat procedure. The MR imaging provided does not show X. X would not be supported for a single procedure. Therefore, this request is not medically necessary."

X, PA-C wrote an appeal letter on X stating, "I am writing on behalf of my patient, who sustained a work-related lumbar spine injury on X and continues to experience persistent lumbar radiculopathy. The patient has ongoing lower back pain with associated radicular symptoms consistent with X. The patient has previously undergone X on X, X, and X, each of which provided significant therapeutic relief. Following these X, the patient reported substantial reduction in pain, improved functional capacity, increased tolerance for activities of daily living, and decreased reliance on X. The relief achieved from X demonstrates both diagnostic confirmation of the pain generator and therapeutic benefit. Despite continued X. Given the documented positive response to X, repeating the procedure is medically necessary and clinically appropriate. X is a targeted, evidence-based treatment for X. In this patient's case, X resulted in meaningful and measurable improvement, supporting the medical necessity of continued interventional management to restore function and facilitate ongoing recovery. Without this intervention, the patient is at risk for worsening pain, decreased functional ability, increased medication dependence, and potential progression to more invasive treatment options. Based on the patient's history, clinical presentation, imaging findings (if applicable), and documented positive response to X, a X is medically necessary and appropriate under workers' compensation guidelines. Please approve this request to allow continuation of medically necessary care."

Per an appeal review / reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD noting "An appeal review for medical necessity and appropriateness of the requested service(s) listed below has been conducted on behalf of X. The requested service(s) or treatment(s) are not medically necessary or appropriate. This means we do not approve these services or treatments." Rationale: "ODG notes X may be indicated when there is radicular pain with a duration of X weeks and lumbar radiculopathy by history (e.g., radiation of pain and numbness along the distribution of the affected spinal root), and diagnostic imaging (e.g., CT scan, MRI) correlates with symptoms. The procedure must be

performed X. X is clinically appropriate in patients with good response X, as indicated by documentation of sustained improvement of pain or function of X percent, as measured from baseline, for X weeks after X There must be pain or deterioration in function since X. In this case, the records document that the claimant last underwent X on X. The records do not document a successful outcome from the X, as the claimant reports the pain had recurred by the visit on X. Therefore, the response from the X lasted less than X weeks, which does not meet evidence-based guidelines for effectiveness. Without documentation of sustained improvement in pain or function for at least X weeks, the requested X is not medically necessary."

**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. There is insufficient information to support a change in determination, and the previous non-certifications are upheld.

The Official Disability Guidelines note X may be indicated when there is radicular pain with a duration of X weeks and lumbar radiculopathy by history (e.g., radiation of pain and numbness along the distribution of the affected spinal root), and diagnostic imaging (e.g., CT scan, MRI) correlates with symptoms. The procedure must be performed X. X is clinically appropriate in patients with good response to X, as indicated by documentation of sustained improvement of pain or function of X percent, as measured from baseline, for X weeks after X.

The submitted clinical records indicate that the patient underwent most recent X on X. Prior to the X, the patient reported a pain level of X. Approximately X weeks later, when seen again on X the patient again rated X pain X. It was noted X was taking X. X also reports X relief with bending; however, corresponding physical examination notes only X. There are no objective measures of improvement provided. There is no significant X. Therefore, medical necessity for X is not established in accordance with current evidence-based guidelines and determination is upheld.

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