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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: X; Amendment X; Amendment X; Amendment 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW: · X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was X. X was helping to X. X landed. The diagnosis was spinal instabilities, lumbar region (M53.2X6). On X, X was seen by X, MD for a follow-up of X. With X and X, X noted changes in X. X experienced numbness and tingling in the right leg. There were spasms in X left leg. X was ambulating without assistance. Pain was noted with sitting, standing, and laying or walking. On examination, X BMI was 31.15 kg/m2. Strength of lower extremities was X. Sensory examination was X. The assessment included X. X chief complaints consisted of lumbar spine pain with numbness and tingling to X lower extremities. X had attempted X. Due to X significant X, X was recommended to undergo an X. X was seen by X, MD on X for evaluation of low back pain. X was status X. The low back pain was described as sharp and stabbing. It was constant, rated at X. It was located on both sides of back. The symptoms were worse by activity and range of motion. Associated signs and symptoms consisted of stiffness. X denied any recent X. X stated that pain affected X quality of life and daily activities. On examination, X appeared to be in pain. X was unable to walk backwards on the heel, uncomfortable on walking, and had slumped posture. On examination of the lumbar spine, range of motion was decreased with increase in pain level. Range of motion showed flexion of X degrees, extension of X degrees, and lateral rotation of X degrees. Strength and tone were diminished due to pain. There was X. Stiffness and tenderness were noted at X. X test were positive. Reflexes were X with X. X was X at X degrees. The assessment included low back pain, lumbar radiculopathy, lumbosacral radiculopathy, post-laminectomy syndrome, lumbar spinal stenosis with neurogenic claudication. Dr. X had been recommending X, and X was awaiting X from X primary care provider. X was seen by X, NP on X for preoperative evaluation. The assessment included X. X were reviewed. X had been cleared for X. An MRI of the lumbar spine dated X showed X. At X, there was X affecting on X. At X, there was a X. This represented the most significant level of pathology above the X. At X and 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. Rationale: “Regarding X, ODG notes that X may be recommended for X. There must be favorable psychological evaluation performed by an independent behavioral health specialist. Patient is X, has been X, or X is required urgently due to X. There must be persistent X. In this case, records do not show a X. There is no documentation of a psychosocial evaluation clearing the claimant for X. The claimant has a X, which is not supported by the guideline. Therefore, the requested X is not

medically necessary. Given the requested X is not medically necessary, the requested X is not medically necessary. Recommendation is to deny the request. “Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, MD Rationale: “This is an appeal of a previous denial which noted limited findings on physical exam to support the X request. The claimant was a X was documented. In this case, the records did not provide further documentation that the claimant was able to X. The records did not document X. No X records for the claimant were included for review detailing response and lack of progress with treatment. No recent X were detailed. Review of the lumber MRI report did not identify evidence of X. The current physical exam also did not identify evidence of progressively worsening neurological deficits in the lower extremities to support proceeding with X. Further, the records did not include a X as recommended by ODG. Given these issues which do not meet guideline recommendations, I recommend non-certifying the request for Appeal: X.” In review of the clinical findings, the claimant has continuing lower back and leg pain after undergone a X. Review of the lumbar imaging reports did not identify evidence of X. The claimant’s most recent exam findings did not detail evidence of X that corresponds with the X noted at X. The records did note the claimant was a X. Therefore, it is this reviewer’s opinion that the services in dispute: X is not medically necessary and the prior denials are upheld. X is not medically necessary and non-certified.

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

In review of the clinical findings, the claimant has continuing lower back and leg pain after undergone a X. Review of the lumbar imaging reports did not identify evidence of X. The claimant’s most recent exam findings did not detail evidence of X. The records did note the claimant was a X. Therefore, it is this reviewer’s opinion that the services in dispute: X is not medically necessary and the prior denials are upheld. X is not medically necessary and non-certified.

Upheld

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)**