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Notice of Workers' Compensation Independent Review Decision

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
X
INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a X claimant requesting medical necessity review for the coverage X.
An Electrodiagnostic Testing was performed on X.

On X, the claimant presented with complaints of chronic neck and low back pain that radiates to the left upper extremity and bilateral lower extremity. The pain onset was associated with a specific event work-related injury. They described pain as sharp, shooting, stabbing, aching, burning, throbbing, and constant. They have previously tried X with minimal to no help. Pain is exacerbated by standing, sitting, and walking. Examination of the lumbar spine was X. They were noted to have X. They received X.

During their follow-up visit dated X, the claimant endorsed no significant change since the prior visit X was performed without complications.

The MRI lumbar Spine without contrast on X revealed X. There are decompressive laminectomies with partial facetectomies from the X. There were postoperative changes at the X. The fusion at X. The X laminectomies and postoperative changes at the X. X noted at those levels from the prior exam has been resolved after the surgery. At the X causes mild left foraminal stenosis with mild posterior displacement of the exiting X. Also, left X was seen.

Per the MRI of the Left Hip without contrast dated X, there was X. Further findings include X.

From X, the claimant attended X.

By X, the claimant is status post X. They are also X. Additionally, the claimant underwent X. The claimant is also X. Despite these interventions, they continue to have X. Surgical intervention in the form X was discussed.

On X, the claimant reported right-sided pain described as a sore, linear sensation extending from the hip. They also reported balance problems due to lower leg weakness, a burning sensation on the top of the right foot, and constant soreness that did not improve with sitting or standing. In addition, they described sciatic pain that worsened with certain activities and positions. The claimant also reported left leg weakness causing stumbling, along with burning and stabbing pain in the left thigh. They had previously been evaluated by a hip specialist, who advised X. The claimant has a history of X. Despite these symptoms, they have been working to lose weight and remain physically active. The provider opined that the claimant's X was a direct result of the work-related injury and the associated treatment and recovery. The claimant was advised to X.

A Psychosocial Assessment was completed on X. They were deemed an appropriate candidate for X.

The MRI lumbar Spine without contrast dated X showed a X. Alignment was X. At X causing mild to moderate left foraminal narrowing with mild flattening of the exiting X. At X causing high-grade left foraminal stenosis with mass effect on the X. These findings were stable compared with the prior examination.

On X, the claimant reported a significant increase in pain that began X weeks earlier and was described as severe and debilitating. They reported difficulty bearing weight on the left leg, inability to find a comfortable position, difficulty sleeping, persistent right hip soreness, and overall pain rated at X. The claimant had been taking X for symptom management. They were referred for further evaluation of X, but it was later determined that the provider was not the most appropriate specialist for X. The claimant also continued to have left-sided symptoms that may be related to X. The MRI showed X.

A Notice of Adverse Determination was sent on X regarding the requested X.

In the Notice of Adverse Determination dated X, the prior denial of the X was upheld on appeals. This was an appeal to a prior denial which noted: The records did not show failure of all reasonable non-operative measures such X did not show X. The records did not show more recent X.

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

Answer: Yes, the requested X is medically necessary.

This case involves a X with a history of chronic low back pain after a work-related injury that occurred on X. The claimant is X. They are also X. Additionally, the claimant X. The claimant is also X. An Electrodiagnostic Testing was performed on X which showed X. They have previously tried X with minimal to no help. Pain is exacerbated by standing, sitting, and walking. Examination of the lumbar spine was X. They were noted to have decreased flexion, extension, and tenderness in the cervical area. They received a X. During their follow-up visit dated X, the claimant endorsed no significant change since the prior visit X was performed without complications. The MRI lumbar Spine without contrast X revealed X. There are decompressive laminectomies with partial facetectomies from X. There were postoperative changes at the X. The fusion at X. The X. X noted at those levels from the prior exam has been resolved after the surgery. At the X causes mild left foraminal stenosis with mild posterior displacement of the X. Also, X was seen. Per the MRI of the Left Hip without contrast dated X, there was X. Further findings include X. From X, the claimant attended X. Despite all interventions done, they continue to have X. Surgical intervention in the form of X was discussed. A Psychosocial Assessment was completed on X. They were deemed an appropriate candidate for X. The MRI lumbar Spine without contrast dated X showed a X. Alignment was X. At X causing mild to moderate left foraminal narrowing with mild flattening of the X. At X causing high-grade left foraminal stenosis with mass effect on the X. These findings were stable compared with the prior examination. On X, the claimant reported a significant increase in pain that began X weeks earlier and was described as severe and debilitating. They reported difficulty bearing weight on the left leg, inability to find a comfortable position, difficulty sleeping, persistent right hip soreness, and overall pain rated at X. The claimant had been taking X for symptom management. They were referred for further evaluation of X, but it was later determined that the provider was not the most appropriate specialist for X. The claimant also continued to have left-sided symptoms that may be related to X. The MRI showed X. On X, the prior denial of the X was upheld on appeals. This was an appeal to a prior denial which noted: The records did not show X. Following the insurer's denial, an external review was requested.

After reviewing all the medical information submitted, a denial overturn is supported. The ODG supports X for X. In this review, the claimant has met the ODG requirements for X since the documentation identified that this claimant has chronic low back pain. They are X. Physical examination was X. They continued to have all these severe and debilitating symptoms despite non-operative treatment for at least X months which includes X, X. Lumbar MRI on X showed X at the X. This is directly above their prior X. The reported symptoms correlate to their MRI findings. Furthermore, they do not have any X.

Based on the claimant's clinical presentation, imaging findings, symptom correlation, failure of extensive conservative approaches, and surgical complexity, the requested X is considered medically necessary. The prior denial should be overturned.

SOURCE OF REVIEW CRITERIA:

☐ ACOEM – American College of Occupational & Environmental Medicine UM Knowledgebase
☐ 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
☒ 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)

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

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
X