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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 injured X at work when X was X. X reported this issue began approximately X years ago, but the pain worsened after a recent incident at work. The diagnoses were lumbar post-laminectomy syndrome / post-laminectomy syndrome, not elsewhere classified (X; X spondylolisthesis / spondylolisthesis, site unspecified (X; lumbar radiculopathy (X; muscle spasm of back (X; chronic pain syndrome (X; other chronic pain (X; low back pain, unspecified (X; and long-term (current use of X (X.

On X, X was seen by X, DO for follow-up on right low back pain that was rated X that day. X reported this issue began approximately X years ago, but the pain worsened after a recent incident at work. The pain was described as a sharp sensation primarily located at the right lower back with associated symptoms of radiating pain, numbness, tingling, weakness of the right lower extremity (RLE and stated the radiating pain of the right side traveled down the posterior and lateral aspect of the right lower extremity and had progressively worsened. The symptoms had been constant since onset and seemed to be worse in the morning or with prolonged sitting, standing, or walking. X endorsed X. X had been seen by X. Lumbar range of motion was limited by pain and stiffness. Lower extremity range of motion was decreased with increased pain. Straight leg raise (SLR) test was X on the right side. Strength testing revealed decreased strength at X with bilateral hip flexion (X), but otherwise X throughout the lower extremities. Sensation was diminished in the left X and X dermatomes, but intact otherwise. Standing A/P, lateral, flexion and extension x-rays of the lumbar spine completed that day revealed X. MRI scan of the lumbar spine completed at an outside facility on an unknown date was reviewed that demonstrated X grade X spondylolisthesis; central disc herniation and broad based bulge causing severe

central and bilateral foraminal stenosis. The assessment was X. Conservative treatment options were discussed, which included X; however, X has already tried these treatments for a X; X had participated in X. X was deemed to be a good candidate X. In order to X. X symptoms had caused impairment and loss of function with daily life, work, and / or recreational activity. After discussing, X wished to proceed with the recommended X. On X, X was seen by X, MD when X presented for X. X was adhering to the X. Examination revealed a X. Lumbar spine examination revealed motor strength X with bilateral hip flexion, knee extension / flexion, and ankle dorsiflexion / plantar flexion. Reflexes were absent at the knees / ankles. On palpation, the lumbosacral paraspinals were tender bilaterally; however, the spinous processes and sacroiliac (SI) joints were nontender bilaterally. Sensation was decreased to light touch through the bilateral X extremity dermatomes. Range of motion was X as was the rest of the examination. An MRI of the lumbar spine obtained from an outside facility was reviewed that showed multilevel degenerative changes; grade X spondylolisthesis and a disc herniation at X with cephalad migration that resulted in severe canal and bilateral foraminal stenosis. X diagnoses were lumbar post-laminectomy syndrome, X spondylolisthesis, lumbar radiculopathy, history of X. X continued to report frequent falls due to increased leg pain and numbness; X pain had been present since X initial injury at work in X and had been progressively worsening. X had radiographic findings on MRI consistent with spondylolisthesis and stenosis. X symptoms had failed to significantly improve despite X weeks of X. X. Per the urine drug screen dated X, the report showed X. X was to continue X. X was seen by Dr. X (spine surgeon) who had recommended X. X prescription drug monitoring report was reviewed and was consistent.

A CT of the thoracic and lumbar spine dated X demonstrated X.

Treatment to date included X.

Per a Peer Review Report / Utilization Review Adverse Determination note dated X, the request for X was denied by X, MD. Per the review question, "1. Is the request for X medically necessary?" Dr. X responded, "Non Certified." Rationale: "ODG Criteria X may be recommended for 1 more of the following: X or more of the following are present: X. Symptoms requiring treatment, as indicated by the presence of ALL of the following: X: Assessment of motivation for recovery md RTW Assessment reveals X. Evaluation of personality style and coping ability. Patient is X. Treatment is indicated by ALL of the following: Failure of X: Failure of symptoms to improve despite X months of nonoperative treatment, including 1 or more of the following: X. X 1 or more of the following are present: X. X, as indicated by 1 or more of the following: X and ALL of the following are present: Treatment is indicated by ALL of the following: X, as indicated by 1 or more of the following: X, including 1 or more of the following: X, including 1 or more of the following: X, including ALL of the following: Assessment of motivation for recovery and RTW Assessment reveals X. Evaluation of personality style and coping ability. Patient is X. X demonstrated on imaging. Symptoms correlate with findings on MRI or other imaging. Rapidly progressive or very severe symptoms of X, and imaging findings of X. ODG Criteria X is NOT recommended for any of the following (1) (2): X. A prior denial indicated the records did X. No X were included. Review of the lumbar imaging report did X. Furthermore, the records did not include a X. The requested X is not medically necessary. The submitted medical records do not indicate that the X. The records do reflect a X. Records do reflect that the patient has X. The objective findings do X. Additional objective information is necessary. Medical necessity has not been established. Therefore the request for X is non-certified."

The records also documented a Notice of Adverse Determination dated X addressed to Dr. X noting, "This correspondence pertains to the review of the following health care service(s). After peer review of the medical information presented and /or discussion with a contracted Physician Advisor and the medical provider, it has been determined that the health care service(s) requested does not meet the established standards of medical necessity. This review applies only

to the specific service(s) listed below. Any additional service(s) will require a separate review process." "Specific Request: X" "Determination: Non-certified by Physician Advisor" "Start Date X and End Date X" "Physician Advisor Decision Date: X." "The above review was made based on the adopted treatment guidelines for the Texas Department of Insurance, Division of Workers' Compensation, Official Disability Guidelines, excluding X."

Following the Notice of Adverse Determination dated X, X wrote an undated appeal letter stating, "To whom it may concern. My name is X. I am under the care of Dr. X, pain management, and Dr. X, surgeon. I have had two appointments with Dr. X both appointments X has tried to get this X approved. Both doctors have said I need this X. I am in pain daily. I had to start using a X. I have had to become dependent on X to X. Another reason I have had to start X is because X. Also I am having incontinence issues due to my back issues." X then provided a brief summary of X medical treatment visits with Dr. X and Dr. X, the surgeon. They discussed X. X also stated that X. X had enclosed several of X MRIs back to X and the CT from X.

X wrote another undated appeal letter noting, "To whom it may concern: My name is X. I am under the care of Dr. X, pain management, and Dr. X, surgeon. I have had two appointments with Dr. X, both appointments X has tried to get this X approved. Both doctors have said I need this X because I could become X. I am in pain dally. I had to start using a X to be able to walk around my house without

falling. I also have had to get X to use so I can X Also I am having incontinence issues due to my back issues. I have X. This is another reason why I use a X. I see Dr. X at X. X address is X. I have been see X since Dr. X retired."

Per a Peer Review Report / Reconsideration / Appeal Review Adverse Determination dated X by X, MD, the attending provider (AP), X, was called at X on X and Dr. X spoke with Dr. X. Per their discussion, Dr. X stated that X could not X. Moreover, Dr. X did not typically send claimants out for X. No other information was given. A call was placed on X to notify the AP of the determination. A message with the determination was X(X voicemail. Per the review question, "1. Is the Appeal X medically necessary?" Dr. X responded, "The request is not medically necessary. Rationale: "The available records still X. Given these issues, which do not meet guideline recommendations, this reviewer cannot recommend certification for the request. Therefore, the request for Appeal X is not medically necessary."

The records also documented a Notice of Adverse Determination dated X addressed to Dr. X noting, "This correspondence pertains to the review of the following health care service(s). As requested, X. The second physician has upheld our original non-certification. Specific Request: Appeal X. Determination: Appeal Upheld by Physician Advisor." "Start Date X and End Date X." "Physician Advisor Decision Date: X." "The above review was made based on the adopted treatment guidelines for the Texas Department of Insurance, Division of Workers' Compensation, Official Disability Guidelines, excluding X."

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

In this case, the review of the submitted documentation of the X. There was no evidence of X. Furthermore, the records did not include a X, including ALL of the following: X The requested X is not medically necessary. The submitted medical records do not indicate that the patient underwent a X. The records do reflect X. The objective findings do X. Additional objective information is necessary. Medical necessity has not been established. Therefore, the request for X 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