

# US Resolutions Inc.

An Independent Review Organization  
3267 Bee Caves Rd, PMB 107-93  
Austin, TX 78746  
Phone: (361) 226-1976  
Fax: (207) 470-1035  
Email: manager@us-resolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** May/07/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

X-ray, Lumbar/Sacral Spine

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

D.C., Board Certified Chiropractic Examiner

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines

Request for IRO 04/30/12

Utilization review determination 04/03/12

Utilization review determination 04/19/12

Operative report 11/19/08

Clinical records Dr. 10/23/08-03/26/09

MRI lumbar spine 10/23/08

Clinical note Dr. 12/01/08

Request to change treating doctor 03/28/12

Clinical notes Dr. chiropractor

MRI of the Lumbar spine 10/05/01

Letter of appeal Dr. DC 04/16/12

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who is reported to have sustained work related injuries to his low back on xx/xx/xx. He had MRI of the lumbar spine on 10/23/08. This study notes a transitional vertebral body with lumbarization of S1, chronic compression fractures of L1, T12 and T11, degenerative changes at L5-S1, and a left foraminal far lateral disc bulge at L4-5.

Dr. recommends that the claimant either quit construction or undergo an instrumented fusion. The claimant underwent anterior lumbar interbody fusion with decompression on the right at L5-S1 on 11/19/08. Post-operatively the claimant has continued elevated levels of pain. Records indicate that the claimant was ultimately allowed to return to work on 03/26/09. There are no interval clinical records. On 03/28/12, the claimant changed treating providers to Dr., DC. The claimant is reported to have low back pain with radiation into the right lower extremity. Dr. requested plain radiographs of the lumbar spine. The initial request for

radiographs of the lumbar spine was reviewed by Dr. DC who non-certified the request noting that there has been no evidence of any low back care for the last three years. He indicates the claimant presented with acute low back pain of unknown origin on 03/30/12. He notes that the current provider did not perform an examination and requested lumbar x-rays. He finds that there is no clinical support for the request. The appeal request was reviewed by DC who non-certified the request. A peer-to-peer discussion was completed. In discussion with Dr., it was reported that she no longer was requesting a radiographic evaluation. She stated that following a further review of the treatment notes that the claimant had been referred for second opinion consultation with pain management specialist, physiatrist or orthopedist. The request was subsequently withdrawn. Of note the request for IRO was submitted as life-threatening.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The submitted clinical records indicate that the claimant has a history of L5-S1 fusion secondary to work related injury. There is a large gap in the treatment record and the claimant presented with complaints of low back pain with radiation into the lower extremity. This appears unchanged from the claimant's past medical history. There is no indication of a progressive neurologic deficit and a detailed physical examination was not documented in the clinical records. The requestor is noted to have withdrawn the request for imaging studies. The reviewer finds no medical necessity at this time for X-ray, Lumbar/Sacral Spine.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)