I-Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 IR
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 790-2280
Email: @i-resolutions.com

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. The biomechanics of the injury was not available in the records. The diagnosis was compression fracture of the thoracic vertebra. On X, X, MD evaluated X for chief complaint of lower back / lumbar problem. X had low back pain, sharp in quality, and X in severity. X had moderate back pain. The pain was located at midback down the low back. The pain had not improved since the injury. The pain was dull and achy. The pain started at work on X. X was X. X ongoing medication included X. X was wearing the back brace with limited relief. X had done a round of physical therapy with limited relief. X used to see Dr.X. X worked for X. X had not worked since the injury. On examination, lumbosacral spine revealed mid back pain tenderness to percussion. Range of motion was decreased with extension. Facet loading test was positive bilaterally. X had failed all conservative therapy such as physical therapy, medications, and back brace. The X had progressed since X to 50% height loss with persistent marrow edema. X continued to have tenderness to percussion at the site. The pain was debilitating that X could not work. The X was recommended to restore height so X may return to work. An MRI of lumbar spine dated X revealed X. Diffuse marrow edema in the X vertebral body was rioted and there was 30-35% loss of vertebral body height. There was degenerative disc disease at X with loss of disc height and disc desiccation. There was marrow edema seen previously along the superior X end plate was no longer visualized. There was a X mm broad-based posterior disc protrusion mildly indenting the ventral thecal sac. There was moderate right foraminal narrowing at X. Treatment to date included medications X. Per a Peer Review Report dated X by X, MD, the request for X was denied. Rationale: “Per ODG, X requirements include a fracture associated with cancer, a fracture not older than three months, and a vertebra that has not lost more than one third of its height. This claimant’s condition does not meet any requirements mentioned above. I spoke with the PA to discuss the claimant’s clinical status and X history. All pertinent facts were confirmed. Therefore, X is not medically necessary. “Per a letter dated X, X, PA-C documented that X was a new patient. X determined that it was medically necessary and beneficial to X to have a X. As noted from that office visit, X had

failed X. A X had progressed since X to 50% height loss with persistent marrow edema. X continued to have tenderness to percussion at the site. X pain was debilitating that X could not work. Dr. X believed this would help X return to work. Based on ODG guidelines, X matches 3 of the 5 criteria for a X. X had lack of satisfactory improvement with medical treatment. X had an absence of alternative cause for X pain. X vertebrae had lost 50% height as well. On top at this, X did not meet the criteria for not exceeding three months as X reported that X had been delayed in receiving care for X fracture. and was sent to physical therapy first. X appreciated the opportunity to appeal this case for X. Per a Peer Review Report dated X by X, MD, the request for X was not medically necessary. Rationale: “This is an appeal of a previous denial which noted that current evidence based guidelines do not recommend X. ODG does not recommend vertebral augmentation procedures such as X. There is no evidence that the X is the result of multiple myeloma or other non-metastatic cancer related causes. Further, the compression fracture age is more than 3 months. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request. Therefore, the appeal request for X is not medically necessary. “The requested X is not medically necessary. The guidelines do not support X. The fracture is now X months out from the date of injury. No new information has been provided which supersede the recommended guidelines. X medically necessary? 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:

The requested is X not medically necessary. The guidelines do not support X. The fracture is now X months out from the date of injury. No new information has been provided which supersedes the recommended guidelines. X medically necessary? (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)**