US Decisions Inc.
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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: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

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was X. The diagnosis included strain of muscle and tendon of back wall of thorax and chronic pain syndrome. On X, X was seen by X, MD for low back pain. The pain radiated into the right lower extremity. X was able to stand less than X minutes. X was able to sit for less than X minutes, able to walk for less than X minutes. X pain level was X at the time. Pain at worst was X and at best was. X described X pain as aching and soreness that comes and goes. Pain was better by X. Examination showed blood pressure was 130/84 mmHg. X was refilled with X. An X of the lumbar spine dated X showed X. X was seen with X. X were noted. At X. X was present, symmetric. At X. X were present. At X. There was X. This was not a new finding. No pathologic enhancement following contrast administration was noted. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the retrospective request for X is non-certified. Rationale: "The injured worker complains of low back pain. The pain radiates to the right lower extremity. The pain is rated at X. A physical examination stated no significant changes from the last office visit. X of the lumbar spine dated X. There was X. X are present. X, was noted. There are insufficient objective findings to support the medical necessity of the request. No examination findings with pathology were noted to consider this request. Therefore, the requested X is not medically necessary. "Per a reconsideration review adverse determination letter dated X by X, MD the appeal request for X is non-certified. Rationale: "The medical information available for review shows no documentation of current subjective complaints, objective findings, treatment goals, or the injured worker's response to treatment. The guidelines do not support the request. Therefore, the requested X is not medically necessary and non-certified. "Thoroughly reviewed provided records including provider documentation and peer reviews. Though provider has minimal documentation regarding pain issues, it does appear that patient was being successfully treated for low back pain with subjective improvement noted with X. X needs to be X. Patient's current X were included - noted that patient has X. If patient did not get X. It appears that X was medically necessary to be performed. X is medically necessary and certified

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

Thoroughly reviewed provided records including provider documentation and peer reviews. Though provider has minimal documentation regarding pain issues, it does appear that patient was being successfully treated for low back pain with subjective improvement noted with X. X needs to be X. Patient's X were included - noted that patient has X. If patient did X. It appears that X was medically necessary to be performed. X is medically necessary and certified Overturned

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)**