Pure Resolutions LLC
An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 779-3288
Fax: (888) 511-3176
Email: @pureresolutions.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. X reported X. X had a X. X had right lower leg and right

knee pain. X had contusion to shin mid shaft with mild swelling. X knee was stable. The diagnoses were strain of lumbar spine, contusion of right knee, and contusion of right lower leg. X was seen by X, MD on X for complaint of low back. X stated the pain was still the same. The onset of the pain was sudden. The pain was severe. X reported X was still having pain in the back and numbness down the leg to the foot. X stated it seemed to be happening more often. The pain was rated X. The therapy had not helped. On examination, weight was 150 pounds and heart rate was 92 beats per minute. On examination of the back, there was tenderness to palpation noted over the left paraspinal muscles and left sacroiliac joint. There was decreased range of motion with both flexion and extension. The deep tendon reflexes were X in right knee, X in left knee and absent in the right ankle. The gait favored the right leg. X was unable to balance on right leg. The straight leg raise was with pain at X on right. Examination of the right knee showed full flexion and extension, and no pain on palpation. X as needed was prescribed. Dr. X discussed X injury and reviewed the lumbar spine x-ray. X had some X X but otherwise the study was unremarkable. X MRI was denied though X had progressive neurological changes over X months of conservative care. X had a normal x-ray for X age at the time. A request for X would be submitted as it met the ODG criteria for imaging. X would remain on restrictions. An x-ray of the right tibia and fibula dated X showed no acute osseous abnormality of the right tibia or fibula. An x-ray of the right knee dated X revealed no acute osseous abnormality. Intact X was noted. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the prospective request for X was noncertified. Rationale: “Upon review of submitted documentation, the claimant sustained an injury by way of an undisclosed mechanism. The claimant was diagnosed with lumbar spine strain and right knee contusion. Relevant comorbidities included X. As a result of injuries, the claimant was unable to tolerate heavy lifting. The claimant’s current work status was regular duty. Modified work had been recommended, however X employer was unable to accommodate the restrictions. Attempted treatment was undisclosed. X-ray of the right knee and lower leg were reportedly negative for fracture. Per the X progress note by X, MD, the claimant reported worsened lower back pain and has not started therapy. Also, X job is not respecting X work restrictions. Moreover, X reports increased numbness in the legs. The provider recommended X. Regarding X, the Official Disability Guidelines stated the general recommendation for X, is that there should be evidence of severe progressive neurologic impairments or

signs or symptoms indicating a serious or specific underlying condition. Alternatively, imaging may be appropriate prior to invasive interventions. The requested X is not supported at this time. Remarkably, there does not appear to be any indication the claimant has undergone initial x-ray imaging of the lumbar spine. Therefore, the medical necessity for X has not been established. Hence, the request for X is non-certified. “Per a reconsideration review adverse determination letter dated X by X, MD, the prospective request for X was noncertified. Rationale: “The prior non-certification for the request for X was non-certified in review X on X based on there not appearing to be any indication that the claimant had undergone X The provider submitted interval reporting in detail that the claimant’s ongoing low back and right lower extremity pain. An x-ray finding for the X were also included. It did not appear that lumbar x-rays had been previously taken. The provider was appealing the prior determination at this time. Regarding X, the Official Disability Guidelines suggest that it may be recommended for patients with ongoing low back pain after at least six weeks of conservative treatment. Radiography should be the initial imaging choice for most low back injuries. It appears that the previous non-certification was appropriate. Per the available reporting, it does not appear that the claimant has had X. Given that there are no red flags warranting prompt X is not reasonable without initial x-rays. Based on this, the request for X is non-certified. “The requested X is medically appropriate. According to the submitted medical records, the patient has obtained an x-ray of the lumbar spine dated X. There was some X. The records reflect ongoing pain despite X. An examination does demonstrate neural tension signs with a positive straight leg raise. Given the failure of conservative treatment, examination findings and submitted x-rays, the requested X is medically appropriate and falls within the appropriate guidelines. X is medically necessary and certified

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

The requested X is medically appropriate. According to the submitted medical records, the patient has obtained an x-ray of the lumbar spine dated X. There was some X. The records reflect ongoing pain despite X. An examination does demonstrate neural tension signs with a positive straight leg raise. Given the failure of conservative treatment, examination findings and submitted x-rays, the

requested X is medically appropriate and falls within the appropriate guidelines. 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

☐ 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

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

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL