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***Notice of Independent Review Decision
Amendment X***

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 stated that X was X, when X fell on X right side and hit X head on a X, causing severe pain of the head, neck, right side of low back, right hip and right leg. The diagnosis was cervical sprain / strain and lumbar sprain / strain. On X, X was evaluated by X, MD for follow-up of a work-related injury. At the time, X rated pain X, sharp in nature. X stated it was no better. X was unable to work but was working light duty. X felt the pain constantly. Movement made X pain worse and nothing made it better. The pain radiated to the right and left lower extremities. X was following the treatment plan, but it did not help. X had been denied X. X had received X. X had not helped. X had not had any X. On examination, vitals were stable. Musculoskeletal examination revealed flexion, extension, and rotation of the cervical spine to be decreased by X in all planes. There was good X motor strength in the upper extremities. There was some potential decrease in the sensation of the X with X on the right side. Toe and heel walking was good. Flexion, extension, and rotation of the lumbosacral spine were decreased by X in all planes. X had a positive X on right, negative on left. There were X at the X and X bilaterally. The assessment was lumbar sprain and strain and cervical sprain and strain. Dr. X noted that the denial of X was prolonging X care, and they would appeal this. Due to lack of improvement with conservative treatment at the time in the treatment plan, Dr. X felt that X would benefit from X, which would be X. The procedure was necessary to identify the pain generator (s) and to relieve pain so that X could participate in a higher level and more meaningful rehabilitation program with the hope of returning to the former employment or continue with the ongoing employment either modified or regular work. Dr. X noted that X is supported by evidence-based studies which have been summarized in the review study by X, and kindly requested that the peer review physician be a board-certified specialist who was actively practicing in the field of interventional spine care. Dr. X was certain that X / X was familiar with the article by X and was well aware of the strong evidence-based data available to support Dr. X request for the above procedure. Dr. X did not feel that a non-interventional or non-surgical physician had the adequate personal hands-on experience to deny this request. Dr. X noted

that X had reached a point in the treatment plan where the determination was to now proceed with a X. This decision was based upon the complex nature of the injury, how it was impacting X bodily function, as well as the fact that they had exhausted all conservative treatment options, which included X. X would require this X in order to retain / regain X bodily function and process toward pre-injury functionality. X had elected to proceed with the X. In addition to this, because of delay of care, Dr. X noted X would ask for surgical evaluation because X was not improving and had a X at X, which was touching the X. On X, X was evaluated by Dr. X for a follow-up visit. X had been denied X. X felt no better and actually felt worse. X pain was rated at X. X was unable to work. X pain was constant. It was made worse on shoulders, both sides, left getting worse than the lower extremities. X was following the treatment plan, but it was not helping. X was taking X, which helped a little bit. X had X without any improvement. X provided no improvement. X had been denied X even though the orthopedic spine surgeon had recommended X, thus delaying care. Musculoskeletal examination revealed flexion, extension, rotation of the lumbosacral spine decreased by X in all planes. The X was X on right. X was present bilaterally in the neck at the X and X level. X of the cervical spine was decreased. Flexion, extension, and rotation of the cervical spine was at X in all planes. Dr. X noted they would appeal for the denial of X. X would also make a referral to a psychological evaluation for X, as X was asking for a X. An x-ray of the cervical spine dated X revealed X. There was X seen at X. There was no significant change present compared to the prior study on X. An MRI of the cervical spine dated X revealed X. There was X. At the X level, X was present, resulting in X. There was X of the left X. At the X level, broad-based X was present, resulting in X. There was X of the left X. Treatment to date included medications (X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Official Disability Guidelines conditionally recommend X prior to considering X. On X, the claimant presented with pain in the neck, lower extremity, and back. My pain level was X. Pain radiates into the right lower extremity and somewhat into the right upper extremity. X has received multiple sessions of X. X did not really help. X has had an MRI of the cervical spine which showed X. Cervical spine examination showed X noted. In this case, the actual MRI report was not submitted for review. Furthermore, the guidelines require documentation of at least X months of X. As such, the medical necessity has not been established for X. Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale:

“Per Official Disability Guidelines (ODG) by MCG, "Clinical presentation should be consistent with Facet joint pain, signs and symptoms referenced above. X involves X. X is not recommended for the thoracic spine. (1) Absence of radicular pain, spinal stenosis, previous fusion (same level), infection, tumor, coagulopathy, or anticipation of a surgical procedure.” In this case, physical examination was notable for a X. The request is not shown to be medically necessary. Therefore, the requested X is non-authorized. “The submitted medical records do not support the requested. The medical records indicate the presence of examination findings consistent with radiculopathy as there is a X. In addition, it is not clear that the patient has attempted at least X months of conservative treatment. Thus, the standards for the requested treatment have not been met. 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 submitted medical records do not support the requested. The medical records indicate the presence of examination findings consistent with X. In addition, it is not clear that the patient has attempted at least X months of conservative treatment. Thus, the standards for the requested treatment have not been met. 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)**