US Decisions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 US
Austin, TX 78731
Phone: (512) 782-4560
Fax: (512) 870-8452
Email: @us-decisions.com

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who sustained an injury on X. Per the review, X was involved in a X. The diagnoses included bilateral sacroiliitis. X was seen by X, MD on X for a follow-up visit. X complained of pain in low back, neck, and sciatica. X reported increased left buttock pain at X with medication and X without medication. X also endorsed pain in the neck, left arm, right shoulder, low back, hip, and right leg. The pain was described as aching, stabbing, and burning. X was status X. On examination, the right sacrolliac (SI) joint was noted to be markedly improved. The X. There was X. X exhibited pain in the right hip with internal rotation. Motor strength was X in right arm, shoulder, and wrist. Reflexes were decreased at X. Cervical spine examination revealed X. On X and X, X reported that since the prior visit X left sided low back pain had worsened. The right side was doing well since the X. The request for left had been approved initially but the insurance had denied it. X was on X. The side effects of the medication included X. X rated X pain X with medications and X without medications. Physical examination was unchanged from the prior visit. X-rays of the X. MRI of the lumbar spine on X revealed X. Treatment to date included medications X. Per utilization review by X, MD on X, the request for X was non-certified. Rationale: “Regarding the request for X, the ODG by MCG states X. In this case, the claimant reports left buttock pain that has increased. However, there is a lack of documentation to support the claimant has undergone at least X months of X. Additionally, a review of records performed on X by Dr.X, revealed the X. The provider also stated there was a lack of evidence to support the X. Medical necessity cannot be established. Therefore, the recommendation for X, per X order, is for noncertification.” Per utilization review by X, MD on X, the request for X was non-certified. Rationale: “The Official Disability Guidelines conditionally recommend X. On X, the claimant was seen for a follow-up visit and reported increased left buttock pain at X with medication and X without medication. The claimant also reported pain to the neck, left arm, right shoulder, low back, hip, and right leg. The claimant is X. On examination, the X. The X. There was X. There was pain to the right hip with internal rotation. Reflexes were decreased at X. The x-ray noted X. The claimant X. Sacrum MRI dated X noted X.

Mild degenerative changes in the X. No X seen. Lumbar MRI dated X: Postoperative changes of X are noted at X. The X intact and X. At X is noted that is X. There is X. At X is noted. At X is noted, most prominent posteriorly. There is X . At X is noted with an X. The disc X. There is X. This request was previously reviewed and denied as there is a lack of documentation to support the claimant has undergone at least X months of X. While there is the documentation for pain to the X. As such, the appeal request for X, per X order is noncertified." Per utilization review by X, MD on X, the request for X was non-certified. Rationale: "The ODG states X. The examination revealed X. This request was previously reviewed and denied on X and X as there was a lack of documentation to support the claimant has undergone at least X. Additionally, there was a X. This determination remains upheld as significant new information has not been submitted to support this intervention outside the previous determination. The medical necessity of this request cannot be established. The recommendation for X is for non-certifications." Thoroughly reviewed provided records including imaging results and peer reviews. It appeared that patient may have had insurance approval for X. X was ultimately treated with X. Unclear why reviewers stating "lack of evidence to support the X. Though it is not directly stated if patient X. Much of this therapy would have encompassed any potential treatment for the X. 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 imaging results and peer reviews. It appeared that patient may have had X. Regardless, this patient has had X. X was ultimately treated with X. Unclear why reviewers stating "lack of evidence to support the X. Though it is not directly stated if patient had X. Much of this therapy would have encompassed any potential treatment for the X. 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)**