Independent Resolutions Inc.
An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (682) 238-4977
Fax: (888) 299-0415
Email: @independentresolutions.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 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. At that time, X was injured when X. Initially, the pain was not as significant and the gradually the pain got much more significant. The diagnosis was other intervertebral disc degeneration, lumbar region (M51.36).On X, X was evaluated by X, MD for a follow-up visit for lower back pain. X had done physical therapy and really did not feel like X was any better. X continued to get the pain in X back which was sharp shooting pain into X gluteus muscle and buttocks down X left leg to knee. X occasionally got some numbness or tingling in X left foot. The symptoms were not on the right leg and X had no loss of control of X bowel or bladder function. X had been X. X was also managed with X. The X, gave X temporary relief of the X. The pain continued to bother X with back pain and the pain in the buttocks and down the leg to the point where X really could not return back to X job and occupation. Overall, X did not feel that the X. X worked in X job and occupation as X and returned on the day with X rehab to discuss X treatment option. Lumbar spine examination revealed X. X was X. X was X. X was X. X were X. There was X. The X was X. X-rays of lumbar spine dated X revealed X. The X. X was X. X did X. On assessment, X continued to have symptoms that were bother X on a daily basis. The previous x-rays and MRI's were reviewed. X had some X. X did have X. It was discussed at length about X lower back and the radiculopathy into X left lower extremity and discussed that if X could exercise stretch strengthen and return back to X job and occupation as a X and live with the discomfort X should try to

live with it. X really did not feel like X could work through it and live with it on day-to-day basis. The symptoms gave X too much trouble on a regular basis with a component being the back pain and a component being the buttocks and leg symptoms. After reviewing both of X MRI's very carefully, it was recommended that a X. They also discussed from surgical perspective the X. The plan was to proceed with a X. An MRI of lumbar spine dated X revealed there were X. At X. At X. At X. Treatment to date included X. Per a peer review report dated X, by X, MD, the request for X was denied. Rationale: "The claimant has X. Therefore, the request for X is not medically necessary. "Per a utilization review report dated X, the request for X was denied by the physician advisor. Rationale: "After peer review of the medical information presented and/or discussion with a contracted Physician Advisor and the medical provider, it has been determined that the health care service(s) requested does not meet established standards of medical necessity. "Per a peer review report dated X by X, MD, the appeal request for X was denied. Rationale: "The claimant had reported ongoing lower back and left leg pain which had not improved with X. However, the claimant's imaging report for the X. X was detailed. The current physical exam was negative for any specific deficits in the left lower extremity which correlate with reported symptoms. The records also did not detail failure of non-operative measures as no recent medications or physical therapy records were included in the available records. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request. Therefore, the requested Appeal X is not medically necessary."Per a utilization review dated X, the appeal request for X was denied. Rationale: "As requested, a second contracted physician who was not involved in the original non-certification has reviewed the original information, supplemented by additional medical records submitted and/or peer review discussion(s) with the treating provider. The second physician has upheld our original

non-certification.”The requested X is not medically necessary or appropriate. The imaging report does not support the request. No new information has been provided which would overturn the previous denials. 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 X is not medically necessary or appropriate. The imaging report does not support the request. No new information has been provided which would overturn the previous denials. 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

☐ 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