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

IRO REVIEWER REPORT

Date: X; Amended X; 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 was injured on X. X was pulling a large dog out of a vehicle and X went to pull it forward and felt a sharp jolting type pain in X lower right back and it radiated down X right leg. The diagnosis was lumbar radiculopathy. On X, X, MD evaluated X for chief complaint of low back pain. The pain radiated to the buttock and right leg. The pain quality was sharp and shooting. The pain level with medications was X and pain level without medications was X. The pain interfered with sleep and work. The pain was present since less than one month. The pain was intermittent and sudden. The pain was aggravated by walking and lying and alleviated by medications, ice, and laying on left side. On examination, there was positive straight leg raise test. X had difficulty with walking. X CT scan showed herniated disc at X. The plan was for X, starting X, and X. A CT scan of lumbar spine dated X revealed marked X. Treatment to date included X. Per a peer review and utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "In this case, there is no documented evidence of X. There is no record of a X. There is no record of a X. The request is not shown to be medically necessary. Therefore, the request of X is non-certified. "An appeal letter dated X was included in the records and X was requested. Per a peer review dated X and reconsideration / utilization review adverse determination letter dated X by X, MD, the appeal request for X was not medically necessary. Rationale: "The injured worker has complaints of low back pain The pain was radiating to buttocks and right leg. It was sharp and shooting. The pain was rated X with medications and X without medications Interference with sleep and work. Exam noted X. CT of the lumbar spine dated X showed herniated disc at X. X has tried X. Given there are X. The

Appeal request of X is not medically necessary. Thoroughly reviewed provided records including imaging results and peer reviews. No explanation given for X. Though CT findings appear to show X. Patient does not meet criteria for X. 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:

Thoroughly reviewed provided records including imaging results and peer reviews. No explanation given for X. Though CT findings appear to show X. Patient does not meet criteria for X. 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)**