

**Independent Review Organization (IRO) Notice of Decision Template
WC**

**Physio Solutions LLC
7500 Brooktree Rd STE 300
Wexford, PA 15090**

Notice of Independent Review Decision

x

Amended Decision Date: x

Date Amended Decision Sent to All Parties: x

RE: IRO Case number **TX 3x**

Name: x x

IRO Reviewer Report

x

IRO Case number: TX x

Description of the services in dispute

X

Description of the qualifications for each physician or 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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether **medical necessity exists** for **each** of the health care services in dispute.

X.

Information provided to the IRO for review X

Patient clinical history

X, date of birth X, is a X individual diagnosed with spinal stenosis, thoracic region; spinal stenosis, lumbar region without neurogenic claudication; other fracture of an unspecified lumbar vertebra, sequela; and unspecified injury to unspecified level of lumbar spinal cord, sequela, and seeking coverage for Lumbar Fusion X posterior spinal fusion. It was noted that the claimant sustained an industrial injury on X after being X.

The X Encounter by X, MD noted the claimant had a history of workplace accident resulting in X. Following surgery, X did not regain neurological function in X lower extremities. A X was placed in X that significantly helped X pain but X months ago he began to develop worsening spasms in X legs. It was noted imaging of X spine showed significant X. It was noted surgery would be indicated and involve an extension of fusion from X.

The X Psychological Evaluation by X, Ph. D. noted X.

Per the X Encounter with X, APRN, it was noted most of the claimant's pain is in the low back and bilateral legs and has lasted for more than a year with burning and spasms. Without medication, it is rated a X and with medication, it is rated X. X was noted in X.

The X Review Determination noted prior treatment included X. Relevant comorbidities include X. Prior diagnostic testing included a CT scan of the X. An MRI of the lumbar spine on X X. It was noted during the most recent encounter on X, that Dr. X stated the surgery would include X. It was noted that the surgical request in the most recent note differed from the surgical request being requested for X. The Official Disability Guidelines regarding fusion for low back conditions were cited. However, as the request differed in the clinical note, and additional documentation was not received clarifying this, the request was denied.

Per the X Review Determination, the reason for the prior denial was highlighted. Additionally, it was noted, "A current evaluation of the claimant was not included for review. The most recent evaluation of the claimant was from X and is more than X months old. Given these above noted issues, the request for X is recommended for non-certification."

The X Request Information noted the claimant is requesting a X.

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision.

X, date of birth X, is a X individual diagnosed with spinal stenosis, thoracic region; spinal stenosis, lumbar region without neurogenic claudication; other fracture of an unspecified lumbar vertebra, sequela; and unspecified injury to unspecified level of lumbar spinal cord, sequela, and seeking coverage for X.

Indications for the proposed X. Radiographic evidence reveals X. The claimant's pain control and clinical condition, having been previously stable, have deteriorated in the past year, suggesting a relationship to the radiographic findings.

In short, the proposed procedure should be authorized.

The Official Disability Guidelines state X is conditionally recommended. X may be indicated for one or more of the following: X.

Additional current literature supports this request as well.

Per X, et al, "Surgical treatment of X." Additionally, X., and X note "The surgical correction of X."

As such, the denial is overturned.

Description and source of the screening criteria or other clinical basis used to make the decision

- ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase
- AHRQ - Agency for Healthcare Research and 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
- 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)

Li, Suyun, et al. "Clinical outcome and surgical strategies for late post-traumatic kyphosis after failed thoracolumbar fracture operation: Case report and literature review." *Medicine* 96.49 (2017): e8770.

Alsayed, Mokhtar A., and Mohamed Abd Elaal. "Surgical management of posttraumatic thoracolumbar Kyphosis: A review." *Journal of Family Medicine and Primary Care* 13.3 (2024): 814-818.