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Notice of Independent Review Decision

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)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X who was injured on X. The biomechanics of the injury is not available in the records. The diagnoses were lumbar radiculopathy, pain in lumbar spine, low back pain and displacement of lumbar intervertebral disc without myelopathy. On X, X was seen by X, MD, for Workers' Compensation follow-up visit for lower back / lumbar-spine problem. X presented for postoperative follow-up. X was status X. X also was status post X. X had clinically worsened recently. X was X. This pain was extreme and was limiting X ability to tolerate ambulation. X continued to have burning sensation in X right lower leg. X was having back pain as well. Recently, X had developed bladder problems; X was feeling as though X was losing control of X urine and additionally, X had times when X had lost control of X bowels. X believed that this had been progressively worsening since X. X continued attempting to manage these issues with X. X was taking X. On the day, X was using a X. On examination, weight was 209 pounds and body mass index (BMI) was 30.9 kg/m². X was healthy-appearing and had no abnormality detected (NAD). X was noted, and X was X. Lumbosacral spine showed incisions were healed well, clean, dry

and intact. There was tenderness to palpation of the spinous process at X. There was no tenderness of the paraspinal region bilaterally. Range of motion testing was X. Motor strength was X in left hip flexion and iliopsoas, and left knee extension quadriceps; X in left ankle dorsiflexion tibialis anterior, left great toe extension extensor hallucis longus, and left plantarflexion gastrocnemius. There were absent reflexes (0) seen at bilateral ankle and knee reflexes. There was X. Seated straight leg raising test was X. An MRI of the lumbar spine dated X. There were normal vertebral body heights seen. Mild skin loss at X was noted. Axial reconstructions showed X. X was seen. At X, X was noted. On assessment, X continued to have substantial back discomfort and radiating left lower extremity pain. These issues had recently worsened and at the time, X was having some bowel and bladder changes. X were discussed for pain control. An MRI of lumbar spine was ordered. Per an imaging order dated X, Dr. X ordered X. Treatment to date included X. Per a utilization review adverse determination letter / peer review report dated X by X, MD, the request for X was denied. Rationale: "ODG by MCG Last review/update date: X "X. X." A magnetic resonance imaging (MRI) of the lumbar spine was obtained on X. At X, there is X. At X, there is X. The patient saw the treating provider on X for a telemedicine visit The patient reports right anterior thigh pain. On examination, there is X strength left iliopsoas. Left knee extension is X. Left tibialis anterior (TA) and extensor hallucis longus (EHL) are X. The requested X is not medically necessary. The patient had a X. The guidelines have not been met. Therefore, the request for a X is non-certified. "Per a peer review

report dated X by X, MD, the request for X was denied. Rationale: "The claimant has low back pain. The physical examination of the lumbar spine taken on X revealed X. There was X strength. While the claimant has low back pain, the guidelines recommend this treatment when a X. The claimant had a X. Therefore, the request for X is not medically necessary." Per a reconsideration / utilization review adverse determination letter dated X, the appeal request for X was denied. "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 discussion(s) with the treating provider. The second physician has upheld our original non-certification. "The request for X is not recommended as medically necessary and the previous denials are upheld. Per a peer review report dated X by X, MD, the request for X was denied. Rationale: "The claimant has low back pain. The physical examination of the lumbar spine taken on X revealed X. There was X strength. While the claimant has low back pain, the guidelines recommend this treatment when a X. The claimant had a X. Therefore, the request for X is not medically necessary." Per a reconsideration / utilization review adverse determination letter dated X, the appeal request for X was denied. "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 discussion(s) with the treating provider. The second physician has upheld our original non-certification. There is insufficient information to support a

change in determination, and the previous non-certifications are upheld. No updated physical examination is submitted for review. No prior diagnostic studies were submitted for review. There is a lack of documentation of a significant change in the patient's clinical presentation to support a X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. 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 request for X is not recommended as medically necessary and the previous denials are upheld. Per a peer review report dated X by X, MD, the request for X was denied. Rationale: "The claimant has low back pain. The physical examination of the lumbar spine taken on X revealed X. There was X strength. While the claimant has low back pain, the guidelines recommend this treatment when a X. The claimant had a X. Therefore, the request for X is not medically necessary." Per a reconsideration / utilization review adverse determination letter dated X, the appeal request for X was denied. "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 discussion(s) with the treating provider. The second physician has upheld our original non-certification. There is insufficient information to support a change in determination,

and the previous non-certifications are upheld. No updated physical examination is submitted for review. No prior diagnostic studies were submitted for review. There is a lack of documentation of a significant change in the patient's clinical presentation to support a X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. 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)**