

Amended Notice of Independent Review Decision

Date of Amendment: **X**

RE: IRO Case number **X**

Name: **X**

Description of the services in dispute

X

Description of the qualifications for each physician or health care provider who reviewed the decision

The professionally certified health care provider is board-certified in X

Review outcome

Upon independent review, the reviewer finds that the previous adverse determination 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.

Information provided to the IRO for review

X

Patient clinical history

The claimant, a X, is diagnosed with low back pain (X), unspecified site fusion of the spine (X), unspecified site sciatica (X), other intervertebral disc degeneration in the lumbar region (X), and an unstable burst fracture of the third lumbar vertebra, initial encounter for a closed fracture (X). This review is to determine the medical necessity of X.

The Office Visit Note by X dated X documented the claimant's recent MRI results stating that, "X, I would like for X to try X prior to proceed ins lo any surgical intervention and we will refer X for X with Dr. X. Also recommended X and X continue X medications for now. I will put X on no lifting over X pounds restrictions. Plan to see X back in X months to see how X is doing before discussing surgical options with X."

The Denial Letter by X dated X stated that, "This correspondence pertains to the review of the following health care service(s). 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 for peer discussion(s) with the treating provider. The second physician has upheld our original non-certification. Specific Request: APPEAL X."

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

The claimant, a X, is diagnosed with low back pain (X), unspecified site fusion of the spine (X), unspecified site sciatica (X), other intervertebral disc degeneration in the lumbar region (X), and an unstable burst fracture of the third lumbar vertebra, initial encounter for a closed fracture (X). This review aims to determine the medical necessity of X.

A patient with an unstable burst fracture presents a serious red flag requiring immediate intervention. This type of fracture compromises spinal integrity and poses a significant risk of neurological damage. Immediate evaluation, stabilization, and possibly surgical intervention are critical. Conservative care, recommended for less severe cases, includes self-performed back strengthening and flexibility exercises, aerobic conditioning, and appropriate drug therapies. Passive physical therapy should be avoided, and treatment must be individualized. For the first six months, patients without red flags should actively engage in tailored exercise programs, regularly monitored and adjusted based on their progress. However, an unstable burst fracture necessitates urgent and specialized medical treatment.

For a fracture of the vertebral column without spinal cord injury, the ODG Physical Therapy Guidelines recommend X. Therefore, it is the professional opinion of the medical review to partially overturn the decision to deny the claimant of X. X is not medically necessary for a claimant with X medical history. It is the opinion of the professional medical reviewer that it is medically necessary to recommend X according to the aforementioned guidelines.

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
- 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)
- ODG - Official Disability Guidelines & Treatment Guidelines