

I-Resolutions Inc.

Notice of Independent Review Decision

I-Resolutions Inc.

An Independent Review Organization

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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:

Orthopedic Surgeon

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)

I-Resolutions Inc.

Notice of Independent Review Decision

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

I-Resolutions Inc.

Notice of Independent Review Decision

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X who was injured at work on X. X fell off the X. The diagnoses were failed back syndrome, neural foraminal stenosis of lumbosacral spine, spinal stenosis of lumbar region without neurogenic claudication and history of lumbar spinal fusion. On X, X was evaluated by X, MD, for a follow-up visit of neck and low back pain. X presented for neck and low back pain stemming from a work accident in X when X fell X. X presented a follow up to discuss results of radiographic and other testing. At the time, X rated pain X. X was tolerating provided medications, and pain improved with medications. X was taking X for pain. X had not participated in X. On the day, X presented with persistent pain in X right arm and left leg. X reported that X had previously undergone X, during which a X. However, the X. Despite the X, X body successfully fused the bone in the area. X also reported experiencing pain in X back and leg. The doctor noted that X EMGs showed X. The doctor also noted that X CT scan showed that X body had X. However, the doctor also noted that X body had X. This was presumed to be causing the persistence of the leg pain. X had a history of work injury in X; and a recent X. X reported lumbar pain / injury resulting in instrumented X. Recent CT scan of abdomen and pelvis for abdominal pains was read as demonstrating a X. Dr. X, Pain Management, referred X for spinal evaluation and discussion of the significance of this X. X was diagnosed with post-laminectomy syndrome / failed back syndrome. X were placed in the X timeframe. X related that the X became infected and was subsequently removed. This was followed by a X; all within this time period. X reported that incisions in X neck were related to the spinal cord stimulator surgery. X also related

I-Resolutions Inc.

Notice of Independent Review Decision

the history of X in X and X. Following the X accident, X reported X. X reported that X tried to pull out X. X denied lung issues or pathology. In X, a motor vehicle accident resulted in a X. X had pain management, most recently through Dr. X in X. X had been performed some temporary relief noted. Low back pain with left leg radiation and numbness were X primary complaints. X did demonstrate X. The X of leg did demonstrate X. Dr. X stated that X was not concerned about the X. On examination, X weight was 320 pounds and body mass index (BMI) was 50.11 kg/m². X was well developed, well nourished, in no acute distress. X stooped with a moderately antalgic gait. X breathing pattern was slightly irregular. X was in no distress, though X had a slightly increased respiratory rate. Extremities examination revealed X. Right knee showed status X. Lumbar spine / lower back examination revealed X. There was X tenderness present. There was X. X had flexion with pain at approximately X degrees and extension with pain at approximately X degrees. Straight leg raising test was X. Strength was grossly diminished at X. Skin showed X. There were X. Deep tendon reflexes were X, symmetrical. X as noted. X with stooped posturing was noted. Dr. X remain concerned about X. X supported this concern. X was a surgical candidate for X. An electromyography (EMG) / nerve conduction report of the bilateral lower extremities (BLE) dated X revealed X .A CT scan of lumbar spine dated X demonstrated there was X. This was present on the CT abdomen and pelvis study dated X. An MRI of lumbar spine report dated X demonstrated X. There was X. There was X. There was X. Additional scattered less X was present. There was X. There was X. There was X. Additional suspicion was noted for X. There was X. Correlate for X was advised. Treatment to date included X (X in X, X in X and removal in X, and X in X), X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The X is not medically necessary because as per the guidelines, X is not

I-Resolutions Inc.

Notice of Independent Review Decision

recommended. In addition, the most recent imaging study, the X lumbar CT did not show a X. The study showed X. In addition, the available history and exam did not support a clinical diagnosis of a X. The X is not medically necessary because the X CT showed X. Dr. X disagreement with this reading was not resolved in the available records. The removal of the X is not necessary because Dr. X stated noted they were "not concerned about the X." Because X is not medically necessary, the X is not medically necessary. The recommendation is for non-certification of the request for X." On X, Dr. X wrote an appeal letter regarding denial of request, stated that "I'm not aware that Worker's Compensation guidelines X. The reviewer obviously did not review my medical record that does discuss my disagreement with the radiological reading of the CT scan. In fact, my medical record shows image demonstrating my findings. Regardless, the reviewer obviously did not read the MRI scan of X, that is read as X. EMG study was X. The CT scan was X but the MRI scan of X. EMG did show X. The reviewer states there is X. I agree that I did state that X. I would remind the reviewer that the X. This injured worker that X. These findings correlate with X. My surgical recommendation is medically appropriate and medically necessary to provide relief and pain and suffering for this injured worker. I respectfully request permission to proceed with the recommended medically necessary X. "Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Regarding X, the ODG states X is recommended as an option and may be a first-line or second-line option. X: X: X. Minimally invasive X is not recommended. X is not recommended as a routine procedure for X. Not recommended solely to protect against X. Although X is commonly performed, it should not be considered a routine procedure. The decision to X. X can be challenging and result in complications like X. Current literature does not support X. The request

I-Resolutions Inc.

Notice of Independent Review Decision

is not supported. There is mention that the claimant has not participated in X. Additionally, there is no documentation of X to require the need for the requested X. Therefore, the request for X is non-certified.” “I spoke with X, MD X on X at X CT. Per our discussion, additional supporting records would be faxed for review. At the time of submission, an additional 2 pages of records were received for review that included fax cover-sheets. No additional records were received for review that would support altering the determination. Regarding X. Alternatively, recommend the X. For X.” “The request is not supported. The recommendation is for X requested. As such, the accompanying request is not needed and cannot be certified. Therefore, the request for X is non-certified. I spoke with X, MD X on X at X pm CT. Per our discussion, additional supporting records would be faxed for review. At the time of submission, an additional 2 pages of records were received for review that included fax cover-sheets. No additional records were received for review that would support altering the determination. Regarding X, the ODG states it is recommended as an option and may be a first-line or second-line option. X monitoring may be indicated for 1 or more of the following: X.” “The request is not supported. The recommendation is for the non-certification of the primary X requested. As such, the accompanying request is not needed and cannot be certified. Therefore, the request for X is non-certified. I spoke with X, X on X at X. Per our discussion, additional supporting records would be faxed for review. At the time of submission, an additional 2 pages of records were received for review that included fax cover-sheets. No additional records were received for review that would support altering the determination. “Based on the submitted documentation, there is X. Furthermore, the submitted imaging report does not support the X request. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.

I-Resolutions Inc.

Notice of Independent Review Decision

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the submitted documentation, there is X. Furthermore, the submitted imaging report does not support the X request. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.

Upheld

I-Resolutions Inc.

Notice of Independent Review Decision

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)**

I-Resolutions Inc.

Notice of Independent Review Decision

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)