



Physio
Solutions LLC
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**Notice of Independent
Review Decision**

IRO Reviewer

Report X

IRO Case number: 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 is not medically necessary.

Information provided to the IRO for review

X

Patient clinical history

X, date of birth X, is a X-year-old individual diagnosed with lumbar facetogenic

pain and seeking coverage for X. The claimant fell on the date of injury (X), causing injury to the head, left shoulder, and left upper extremity. No recent use of pain medications was detailed, such as X. No X records were included for review.

The X evaluation by X, MD, noted pain with X. There was pain with X. No X were noted.

Per the Follow-Up Evaluation on X by X, MD, regarding the lumbar spine, the claimant reported X pain. Examination of the lumbar spine revealed range of motion in flexion and extension “remained the same.” No muscle spasms or tenderness were noted.

The Office Visit Note by X, MD, dated X, noted no significant changes in the physical exam since the last office visit.

The requested X were denied due to a lack of records documenting the failure of non-operative measures and a lack of physical exam findings.

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

The claimant is a X year-old individual diagnosed with lumbar facetogenic pain and seeking coverage for X.

In a review of the records, the claimant does present with facetogenic pain findings, as there was reproducible pain in the lumbar region with facet loading maneuvers on the current physical exam. However, the failure of conservative treatment was not detailed. There was no indication that the claimant had recently X. X was not documented. Per the Official Disability Guidelines, X.

Given these issues, it is this reviewer’s opinion that medical necessity is not established, and the prior denials are upheld.

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)