



**Notice of  
Independent  
Review Decision**

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

**X**

RE: IRO Case

number **X**

**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.

## **Information provided to the IRO for review**

X

### **Patient Clinical History**

X, date of birth X, is a X diagnosed with radiculopathy, lumbosacral region and seeking coverage for X.

The claimant was injured on X. X reports on this date, X fell directly onto X back. This fall resulted in lumbar pain with radiation down the bilateral legs and into the toes. MRI lumbar spine dated X shows X. The patient is status post X on X. The note dated X indicates pain is rated X. Note dated X indicates pain level is X. Office visit note dated X indicates that the patient rates pain X. Pain is in the lower back and bilateral legs. Current medications are X. On physical examination sensory exam is intact. Straight leg raising is positive at X degrees. The assessment notes X. The note dated X indicates that pain is X in the lower back and bilateral legs. The exam is unchanged. The note dated X indicates the physical examination is unchanged. Back pain is rated X.

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

The request for X is not recommended as medically necessary. The initial request was non-certified noting that, “The records provided do not document

that the patient has X. Additionally, the records do not show that the patient arrived with at least a X reduction in pain associated with improved function for a period of at least X weeks after the prior X. In the absence of such evidence, the request for a X is not shown to be supported by the ODG nor otherwise medically necessary.” The denial was upheld on appeal noting that, “In this case, X but there is no record of current radicular pain specifically corresponding to these dermatomes.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The claimant underwent X on X. The Official Disability Guidelines require documentation of sustained improvement of pain or function of  $\geq X$ , as measured from baseline, for  $\geq X$  weeks X. The claimant reported X relief for only X days after the X. The office visit note dated X, X weeks after the X, notes that X pain is already rated X. Also, there are no specific measures of functional improvement or decreased medication usage and there are limited objective findings provided on physical examination. There are no updated imaging studies/electrodiagnostic results submitted for review. Therefore, medical necessity is not

established in accordance with current evidence-based guidelines and the X remains denied.

## **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)