

**Applied Resolutions LLC**  
***Notice of Independent Review Decision***

**Applied Resolutions LLC**  
**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: 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

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**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- X

**PATIENT CLINICAL HISTORY [SUMMARY]:**

X who was injured on X. The diagnosis was lumbar radiculopathy.

Please note, no medical records other than 2 utilization reviews were provided for review.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Based on the records reviewed, the patient reported complaints of intermittent low back pain that is rated at X on the pain scale. The pain radiates to the coccyx and buttocks with numbness and tingling in the bilateral feet. The lumbar spine exam showed X. The MRI of the lumbar spine dated X revealed that at X. No neuroforaminal or canal stenosis. The patient has performed X. The provider is requesting X. However, in this case, the patient's physical examination did not document X. Quantifiable measures of objective neurological findings were lacking in the medicals provided to fully validate the presence of radiculopathy. Therefore, this request is not certified."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "ODG by MCG Last review/update date: X: Pain Treatment type: X "Recommended as an option; may be a first-line or second-line option. ODG Criteria X may be indicated when ALL of the following are present (1) (2) (3) (4) (5): X3) (6): X. X performed at X: X: Diagnostic imaging (e.g., CT scan, MRI) correlates with symptoms. Procedure performed via X (7) (8) (9) (10) : X. "Per ODG Low Back guidelines regarding criteria for X, "X may be indicated when ALL of the following are present (1) (2) (3) (4) (5) : X (3) (6) : X: Diagnostic imaging (e.g., CT scan, MRI) correlates with symptoms. Procedure performed X ... Failure to respond to> X, as indicated by ALL of the following (7) (8) (9) (10) : X... X." In this case, lumbar spine MRI revealed X. The request is not

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shown to be medically necessary. Therefore, the request for X is non-certified and upheld.”

Based on the submitted medical documentation and the associated medical records, the requested X is not medically necessary. The imaging reports do not demonstrate X. No new information or records have been provided to overturn the previous denials. 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:**

Based on the submitted medical documentation and the associated medical records, the requested X is not medically necessary. The imaging reports do not demonstrate X. No new information or records have been provided to overturn the previous denials. X is not medically necessary and non-certified.

Upheld

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**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE