Clear Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 CR
Austin, TX 78731
Phone: (512) 879-6370
Fax: (512) 572-0836
Email: @cri-iro.com

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 Overtuned (Agree in part/Disagree in part)

☒ Upheld (Agree)

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 [SUMMARY]: X who was injured on X. X was at work X. The diagnoses included inflammation of sacroiliac joint, lumbar radiculopathy and lumbar post-laminectomy syndrome. X was seen by X, MD on X for hip complaints. Pain was located on the back and the right side. The cause of pain was work injury. Pain was described as sharp, burning, numbness and stabbing. Pain was constant and moderate. Pain was rated as X. Alleviating factors included rest and heat. Aggravating factors included lifting, twisting, bending / squatting and pushing / pulling. Associated symptoms included buckling, numbness and radiation down the leg. Examination showed X was overweight. X gait was antalgic, had a limp and was ambulating with cane. Lumbar spine showed healed incisions. Tenderness of the X was noted. Strength in right ankle dorsiflexion tibialis anterior was X and great toe extensor halluces longus was X. Right and left ankle and knee reflex was diminished (1). Sensation was decreased in X was noted of the posterior thigh (S2). Review of the MRI of the lumbar spine dated X showed at X: Moderately advanced X was noted. There was X. The spinal canal itself was X. There was moderately severe compromise of the X. There was also moderate X. This likely resulted in at X. At X: Pedicle screws and vertical stabilization bars were in place across this level. The spinal canal remained widely decompressed from X. The neural foramina appeared X. At X: X was noted at this level from X. The spinal canal was widely

X. The neural foramina appeared X. At X: X was noted anteriorly. There had been X. The spinal canal was widely X. The neural foramina appeared X. At X: X was noted. The spinal canal was widely X in excess of a centimeter. The assessment included X. X had X, X, X and X. X had exhausted X. X was recommended. At the time X was in active rehabilitation program and would continue after X. A CT scan of the lumbar spine dated X showed X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, DO, the request for X as requested by X, MD at X was denied. Rationale: “Official Disability Guidelines recommends X. On X, the claimant complains of lower back and right hip soreness. Examination shows X. There are no examination and imaging findings indicating presence of X. As such, the request for X is non-certified and is denied. “Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per ODG by MCG Last review/update date: X, Diagnostic X for Hip and Pelvis Conditions Treatment type: Diagnostic Testing, X Not Recommended (generally)-(NR) Not recommended, including X. Diagnostic X are not recommended (a change as of X) as there is no further definitive treatment that can be recommended based on any diagnostic information potentially rendered (as sacroiliac therapeutic intra-articular injections are not recommended for non-inflammatory pathology). Not recommended: X. Per ODG by MCG Last review/update date: X, X for Hip and Pelvis Conditions Treatment type: X Not Recommended (generally)-(NR) Not recommended (neither X) for X, based on insufficient evidence. Recommended on a case-by-case basis as X. The patient was

diagnosed with radiculopathy of the lumbar region. On X, an independent medical examination (IME) performed by X, M.D. indicates that the effects of the compensable injury are resolved. The patient has continued to complain of pain in the lumbar spine. On X, a Computed Tomography (CT) of the Lumbar Spine revealed a X. On X, an x-ray of the lumbar spine revealed X. Straightening of the X is noted. Physical examination revealed there is tenderness of the X. Four out of five (4/5) strength and diminished sensation. There is tenderness in the X. Positive X, positive X and external rotation (X), X, and positive X. The patient is being recommended for X. However, ODG guidelines do not recommend the requested treatment. Therefore, medical necessity has not been established." Based on the submitted medical records, the requested X is not medically necessary. The submitted records indicate that the compensable injury had resolved based on an independent medical evaluation. The records demonstrate that there was X. This does not correlate with SI joint pathology. Furthermore, the associated guidelines do not support the use of X. No new information has been provided which would overturn the previous denials. X as requested by X, MD at 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 records, the requested X is not

medically necessary. The submitted records indicate that the compensable injury had resolved based on an independent medical evaluation. The records demonstrate that there was X. This does not correlate with SI joint pathology. Furthermore, the associated guidelines do not support the use of X. No new information has been provided which would overturn the previous denials. X as requested by X, MD at X is not medically necessary and non-certified
Upheld

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)**

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