

**Applied Resolutions LLC**  
**An Independent Review Organization**  
**1301 E. Debbie Ln. Ste. 102 #790**  
**Mansfield, TX 76063**  
**Phone: (817) 405-3524**  
**Fax: (888) 567-5355**  
**Email: @appliedresolutionstx.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 Overturned      Agree in part/Disagree in part
- Upheld              Agree

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

- X

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

X who was injured on X. The injury occurred when X . Then X slipped forward and felt a pull on X left thigh (back part). The diagnoses were sprain of other parts of the lumbar spine and pelvis; low back pain; other biomechanical lesions of the lumbar region, strain of muscle, fascia, and tendon of the pelvis; strain of muscle, fascia, and tendon of the lower back; and unspecified abnormalities of gait and mobility.

Please note, no updated visit notes or imaging were available for review. However, the most recent notes and imaging from the available medical records are included below.

On X, X was seen by X, NP, for follow-up evaluation of the chief complaint of low back pain that radiated to the left hip. X stated X had been taking X pain medicines, and X pain came and went. X was waiting for surgical date from orthopedic specialty. Regarding lumbar spine pain, X stated that overall, the symptoms had remained the same. Pain remained the same, X. Range of motion remained the same. Radiating pain remained the same. Numbness and tingling remained the same. Lower extremity weakness remained the same. On examination, weight was 210

pounds and body mass index (BMI) was 34.9 kg/m<sup>2</sup>. X was analgesic. Lumbar spine examination showed X. Flexion / extension / rotation remained the same. Muscle spasm along the paraspinal muscles remained the same. Tenderness remained the same. Lower extremities showed range of motion had decreased in all planes with pain. Deep tendon reflexes, sensation, and muscle strength was X. Sitting (straight leg raise) SLR on the left was X. An MRI of the lumbar spine dated X, was reviewed and revealed degenerative changes. There was X. Work status was restricted duty. Treatment plan was to continue X. On X, X was evaluated by X, PT, for physical therapy evaluation visit for X ongoing complaints. X had a history of low back pain since X. X had numerous physical therapy visits and had good and bad days. Recently, X also had X on the lower back with the last one on X. At the time, X continued to complain of lower back pain going up to the neck, noted some pain on the right knee as well. X reported about X pain that aggravated when moving it too much and sitting for long periods of time. It was burning in nature, aggravated when moving too much such as bending, staying in one position whether standing or sitting. X was working and was on work restrictions. Physical examination revealed slow transition from sitting to standing. Lumbosacral spine examination showed range was motion in flexion was X extension X, side bending X on the right and left, and straight leg raise X bilaterally. The manual muscle strength was X in flexion, extension and right and left side bending. FABER test and sacroiliac joint compression test was X. Straight leg raise test was X. Activity limitations included carrying, lifting, pushing, pulling

self-up, stepping up truck steps, bending, squatting, sitting, standing for long periods. X was unable to perform full work tasks as a X; X was on work restrictions. X would benefit from X. X was recommended for X.

An MRI of the lumbar spine dated X, was reviewed by X, NP per the X note, and revealed degenerative changes. There was X. Work status was restricted duty. Treatment plan was to continue X as prescribed.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X, was denied. Rationale: "ODG by MCG, "Evidence-Based Medical Treatment Guidelines", Low Back Section, Physical Medicine Treatment, Intervertebral disc disorder: Without myelopathy Post-surgical treatment; Last review/update date: X. The claimant has received X. While ODG acknowledges that X. The claimant is not working with said limitations in place. The claimant has not worked since X. The claimant remains dependent on a X. Activities of daily living to include those as basic as bending, twisting, sitting, standing, walking, lifting, and carrying remain problematic. All of the foregoing, taken together, suggests that the claimant has either failed to benefit from or has plateaued from a functional perspective with prior care. Additional treatment is unlikely to be beneficial here. Therefore, the request for X is not medically necessary."

Per a reconsideration review adverse determination letter dated X by X , MD, the request for X, was denied. Rationale: "As per ODG, "X. ODG Criteria ODG X Guidelines Please see X. Intervertebral disc disorder: Without myelopathy: X: X. The claimant had X. Subsequent to this, the claimant had completed either at least X. Regardless, it is X months since surgery, and a X was not done. The claimant continues however, with ongoing pain and dysfunction. One would have expected further resolution of symptoms on attrition alone, let alone with X. Thus, given the data provided, further X is not indicated. Therefore, the request for X, is not medically necessary.

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient has had a substantial amount of X. X most recently had X and providers are considering further X. While the patient is beyond cited guideline recommendations for amount of X. Given the noted functional improvement over time, as well as need for recovery from recent interventions, the X request is warranted. X is medically necessary and certified.

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

Thoroughly reviewed provided records including provider notes

and peer reviews.

Patient has had a substantial amount of X. X most recently had X. While the patient is beyond cited guideline recommendations for amount of X. Given the noted functional improvement over time, as well as need for recovery from recent interventions, the X request is warranted. X is medically necessary and certified.

Overtured

**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