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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)

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 at work on X. X was moving a X. X felt immediate pain in the entire spine and right shoulder. The diagnosis was low back pain, both upper lumbar and lower lumbar; X superior endplate fracture with X loss of vertebral height; at X, there was diminished signal central protrusion and posterior central tear; at X, there was a X-mm central protrusion with effacement of the anterior subarachnoid space; and complex tear of the right shoulder labrum. X was evaluated by X, MD on X. X reported being injured at work on X, and felt immediate pain in X entire spine including X neck and low back. X also noted right shoulder pain. X was taken by ambulance to the emergency room where X had a total body scan. X was found to have an X. X continued to complain of low back pain. X also continued to complain of neck and right trapezial pain. Since the X visit, the neck pain was better, but X continued to have right shoulder pain and continued to complain of low back pain. There were two areas, one over the upper lumbar region approximately at X, and one over the lower lumbar region, approximately X. On X, X reported recently having undergone a right X on X. X stated X got some relief for approximately X weeks, and then the low back pain returned. It was all lower back pain, no leg pain. X was in obvious pain. X was very slow in going from a sitting to a standing position secondary to low back pain. X was tender to palpation over the right

trapezius. X was tender to palpation to the lumbar spine. Range of motion of the cervical spine revealed flexion X degrees, extension X degrees, and rotation of X degrees to the left and to the right. Range of motion of the lumbar spine revealed flexion X degrees, extension X degrees which produced low back pain, and lateral bending X degrees to the left and to the right. Facet signs were X. Motor exam revealed X strength in all upper and lower extremity muscle groups. Sensory exam was intact to pinprick. Reflexes were X. Diagnostics were reviewed. The assessment was low back pain, both upper lumbar and lower lumbar; X superior endplate fracture with X loss of vertebral height; at X, there was diminished signal central protrusion and posterior central tear; at X, there was a X. Dr. X noted that with X having X facet signs, X recommended X and X lumbar X. An MRI of the lumbar spine dated X, recent appearing X superior endplate compression fracture with X height loss and no retropulsion into the spinal canal, and X disc bulge with central disc protrusion resulting in no significant thecal sac stenosis. Treatment to date included X. Per a utilization review adverse determination letter dated X, and a peer review dated X, the request for X was denied by X, MD, as not medically necessary. Rationale: "As per ODG guidelines, "Recommended as an option; may be a first-line or second-line option." In this case, there is no record of a X. Therefore, the request for X is not medically necessary. "Per a reconsideration review adverse determination letter dated X, and a peer review dated X, the appeal request for X was denied by X, MD. Rationale: "Per ODG, it is not recommended as a first-line option for treatment of X. Per records, the claimant

had low back pain. Examination revealed obvious pain. X was very slow in going from a sitting to a standing position secondary to low back pain. X was tender to palpation over the right trapezius. X was tender to palpation to the lumbar spine. Range of motion of the cervical spine revealed flexion X degrees, extension X degrees, and rotation of X degrees to the left and to the right. Range of motion of the lumbar spine revealed flexion X degrees, extension X degrees which produced low back pain and lateral bending X degrees to the left and to the right. Facet signs were X. Motor exam revealed X strength in all upper and lower extremity muscle groups. Sensory examination was intact to pinprick. Reflexes were X. There is evidence of benefit from X. Additionally, it is not supported by guidelines. Based on the persistent symptoms and clinical finding, the Appeal request for X is not medically necessary. “Thoroughly reviewed provided records including provider notes, imaging findings, as well as peer reviews. The patient has had continued pain X. While a X was attempted, the current pain is more in the back and not radiating to lower extremities. Based on the cited guidelines, proceeding to X is appropriate. Request for 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, imaging findings, as well as peer reviews. The patient has had

continued pain despite conservative treatment and the pain is in a potentially facet-mediated distribution. While a X was attempted, the current pain is more in the back and not radiating to lower extremities. Based on the cited guidelines, proceeding to X is appropriate. Request for X is medically necessary and certified

Overturned

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)