

True Decisions Inc.
An Independent Review Organization
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***Notice of Independent Review Decision
Amendment X***

IRO REVIEWER REPORT

Date: X; Amendment 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 exact mechanism of injury was not documented. The

diagnosis was other intervertebral disc displacement, lumbar region (X).

On X, X, MD re-evaluated X with respect to a work-related injury sustained while working for X on X. X stated X felt about the same. X reported burning, dull pain in the low back that did not radiate. X could do X of X job. Sitting made the pain worse. Lying and resting made the pain better. X reported no new symptoms. X had been following the treatment plan, which did not help. X was not taking any medications at the time. X had undergone X. X had X, which helped X radicular pain, but X low axial pain was still there. X had MRIs. Musculoskeletal examination revealed toe and heel walking was good. Flexion, extension, rotation of lumbosacral spine had decreased to X in all planes. Straight leg raise was X. Sensory was grossly intact in the lower extremities. Paravertebral spasms were noted at X. The assessment was lumbar sprain and strain. Dr. X would appeal the denial of the X and see X back in a month. Due to lack of improvement with conservative treatment, at that time in the treatment plan, Dr. X felt that X would benefit from X. The procedure was necessary to identify the pain generator(s) and to relieve pain so that X could participate in a higher level and more meaningful rehabilitation program with the hope of returning to the former employment or continue with the ongoing employment, either modified or regular work. Dr. X further noted, "X is supported by evidence-based studies which have been summarized in the review study by X. I kindly request that the peer review physician be a board-certified specialist who is actively practicing in the field of X. I am certain that X/X is familiar with the article by X and is well aware of the strong evidence-based data available to support my request for the above procedure. With all due respect, I do not feel that a X. X can be downloaded via this X."

An MRI of the lumbar spine dated X, demonstrated X. Mild X was detected at this level. There was X. The X measured approximately X mm in size. X was detected at this level. There was X. The bulge measured approximately X mm in size.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The Official Disability Guidelines would support X. Initial X are used to X. This claimant has complaints of lower back pain despite treatment with X. However, progress notes do not include any findings of X. Absent these

objective findings, this request for a X is not certified.”

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “The Official Disability Guidelines (ODG) states that diagnostic X. Guidelines also specify that X. Based on the submitted records, the claimant presented with persistent axial low back pain following X. MRI dated X showed X. However, the clinical documentation does not clearly rule out other potential pain generators such as discogenic or radicular sources. Furthermore, the request includes the use of X. The appeal states that X is medically necessary to identify pain generators and support future rehabilitation, citing peer-reviewed literature. While X may be appropriate as a diagnostic tool, the requested use of X was not supported by ODG standards. As such, the request for a X, is not medically necessary. Recommended for noncertification.”

The requested that procedure is not medically necessary. The medical records do not demonstrate an examination consistent with X. The records reflect that the patient has pain radiating to the both legs suggestive of radicular features. X are reserved for patients with axial pain only. Furthermore, the provider is requesting X for this procedure which is not supported by the ODG criteria. Thus, no new information has been provided which would 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:

The requested that procedure is not medically necessary. The medical records do not demonstrate an examination consistent with X. The records reflect that the patient has pain radiating to the both legs suggestive of radicular features. X are reserved for patients with axial pain only. Furthermore, the provider is requesting X for this procedure which is not supported by the ODG criteria. Thus, no new information has been provided which would overturn the previous denials. 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:

- 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