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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)

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, while employed as a X. X stated that X was X. The diagnosis was strain of muscle, fascia, and tendon of lower back (X). X underwent a Designated Doctor Evaluation (DDE) by X, DC, on X. The purpose of evaluation was to address maximum medical improvement (MMI), impairment rating (IR), and extent of injury. The compensable injury was a lumbar sprain / strain. Dr. X opined that X had not reached MMI at the time. The estimated date of statutory MMI was X. As X had not reached MMI, an impairment rating was not recommended at the time. The extent of injury of X did not extend to include the conditions of X. On X, X underwent a functional capacity evaluation (FCE) by X, NASM-CPT. X appeared to perform the FCE with good effort and had limiting factor of increased pain. The purpose of this Baseline Functional Capacity Evaluation was to determine X. During this evaluation, X was unable to achieve X of the physical demands of X job / occupation. The limiting factor(s) noted during these clinical functional tests included increased pain. X demonstrated the ability to perform within the medium physical demand category (PDC). X demonstrated the ability to perform X of the physical demands of X job as a X. The return-to-work test items X was unable to achieve successfully during this evaluation included firm grasping, pinching, fine coordination, gross coordination, walking, above shoulder reach, occasional overhead lift, occasional pulling, frequent overhead lift, frequent pulling, and sitting. X demonstrated consistent effort throughout X of the test. X reported reliable pain ratings X of the time. On X, X, MD evaluated X for strain of muscle, fascia, and tendon of lower back (X). X continued to have X pain and was unable to work. X reported constant pain made worse by lifting and long standing, and stated lying down made it better. X took X, which were not really helping, X had multiple sessions of X. X had not helped. X had an MRI. X had been denied X. Vitals showed a body mass index (BMI) of 28 kg/m². On musculoskeletal examination, toe and heel walking was good. Flexion, extension, and rotation of the lumbosacral spine was decreased by X to X in all planes. Straight leg raise was X. Motor strength is X in the lower extremities. Sensation was X. Paravertebral spasms were noted at X. The assessment was lumbar sprain / strain. The claimant had been denied X. Dr. X had submitted for a X. Regarding X, Dr. X noted, "Due to lack of improvement with X, at this time in the treatment plan, I feel that patient would benefit from X which will be diagnostic as well as X. The procedure is necessary to X. Risks and benefits of the X has been explained in layman's terms to the patient's satisfaction. Patient understood the X. A copy of the consent as

well as pre/post op instructions were given to the patient for review prior to the procedure. Patient has verbally consented to the procedure. A request for authorization will be submitted for certification. Once reviewed the patient will be scheduled. 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 to deny this request. X article can be downloaded via this link: X." An MRI of the lumbar spine dated X, demonstrated at X. No X was noted. At X. X was seen. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "ODG notes that diagnostic X may be indicated when all of the following are present. X, In this case, the claimant has a X to X percent decrease in X. There are X. Imaging shows no evidence of X. Evidence-based guidelines do not recommend sedation (X). Therefore, while the request for a X would be medically necessary, in the absence of the opportunity to discuss treatment modification, the request in its entirety is not medically necessary. "Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "ODG notes that diagnostic X may be indicated when all of the following are present. X. Treatment includes only X levels, either X. Use of X. In this case, the claimant has chronic low back pain rated as X. The exam shows X. The pain is constant, and the claimant is unable to work. There is lack of improvement with X. Given documented support for a X. The request for X is not medically necessary as evidence-based guidelines do not recommend the use of X is not considered separately identifiable from the X. Had the agreement been obtained, the request would have been supported for X. However, there was no opportunity for discussion to obtain agreement to modify. Therefore, the request for X is not medically necessary. "Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "ODG notes that diagnostic X may be indicated when all of the following are present. X. Treatment includes only X. Diagnostic X is NOT recommended for X, In this case, the claimant has a X to X percent X. There are X. Imaging shows X. Evidence-based guidelines do not recommend X. Therefore, while the request for

a X would be medically necessary, in the absence of the opportunity to discuss treatment modification, the request in its entirety is not medically necessary.” Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “ODG notes that diagnostic X. Diagnostic X. Treatment includes only X. Use of X is not recommended for X. In this case, the claimant has chronic low back pain rated as X. The exam shows X, The neurological examination is X. The pain is constant, and the claimant is unable to work. There is lack of improvement with X. Given documented support for a X. The request for X is not medically necessary as evidence-based guidelines do not recommend the use of X is not considered separately identifiable from the requested procedure X. Had the agreement been obtained, the request would have been supported for X. However, there was no opportunity for discussion to obtain agreement to modify. Therefore, the request for X is not medically necessary.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records document completion of X. X has done a X but this did not help. On physical examination there is X. There are X. While it does appear that X would be an appropriate intervention for this patient, the Official Disability Guidelines note that X are not recommended with the use of X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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 clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “ODG notes that diagnostic X may be indicated when all of the following are present. X. Treatment includes only X. Diagnostic X is NOT recommended for X, In this case, the claimant has a X to X percent decrease in flexion, extension, and rotation of the lumbosacral spine in all planes. There are X. Imaging shows X. Evidence-based guidelines do not X. Therefore, while the request for a X would be medically necessary, in the absence of the opportunity to discuss treatment modification, the request in its entirety is not medically

necessary.” Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “ODG notes that X may be indicated when all of the following are present. X. Treatment includes only X. Use of X care is not recommended for X. In this case, the claimant has chronic low back pain rated as X. The exam shows X, The neurological examination is X. The pain is constant, and the claimant is unable to work. There is lack of improvement with X. Given documented support for a X. The request for X is not medically necessary as evidence-based guidelines do not recommend the use of X is not considered separately identifiable from the requested procedure X. Had the agreement been obtained, the request would have been supported for X. However, there was no opportunity for discussion to obtain agreement to modify. Therefore, the request for X is not medically necessary.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records document completion of X. X has done a X but this did not help. On physical examination there is X. There are X. While it does appear that X would be an appropriate intervention for this patient, the Official Disability Guidelines note that X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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)