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IRO Certificate

Notice of Independent Review Decision

DATE OF REVIEW: X

IRO CASE NO. 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:

Upheld (Agree)

Overtaken (Disagree)

Partially Overtaken (Agree in part/Disagree in part) **X**

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY SUMMARY

This is a X who sustained a work related injury in X, when X

slipped and fell. X was seen by Dr. X on X where X noted point tenderness around T11 and T12 and some tenderness higher up in the thoracic spine. MRI of the lumbar was reviewed from Touchstone Imaging which showed “*mild central compression fracture at T12, moderate central compression fracture at T12, and radiologist report stated that there is an L5 compression fracture*”. There is also note of L4-5 listhesis and L5-S1 listhesis. The actual MRI report is not available for review and the date of the MRI study is unknown. Request is for X to rule out T11 and T12 fracture as well as L5 fracture. ODG allow for X spine for persistent back pain in patient older than X, trauma or fracture of thoracic spine, known or suspected, and one or more of the following: midline spine tenderness, new neurologic symptoms, osteoporosis, known or suspected, plain x-ray or CT scan nondiagnostic, pre-existing spinal pathology, progressive neurological deficit, radiculopathy.

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

Opinion: I partially agree with the benefit company's decision to deny the requested service.

Rationale: I would **agree** that a X would **not** be indicated, **if** a X was already done after X injury on in X (this is unclear from the available documentation).

The request X is not medically necessary in this case.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continued)

Opinion: I partially disagree with the benefit company's decision to deny the requested service.

Rationale: I would, however, **disagree** that an X is **not** medically necessary, given the T12 compression fracture being reported and point tenderness at T11 and T12, and some tenderness higher up in the thoracic spine.

The request X is medically necessary in this case.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continued)

Summary: This review pertains to the need for X after a slip and fall injury and reported concerns for T11, T12, and L5 fractures. It is unclear if the X referenced in Dr. X note was performed after the patient's X injury. If there was already an X performed after the injury, then X would not be necessary. There is no documentation of a previously performed X and there **are** concerns for acute fracture in the thoracic spine.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL &
ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH &
QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION
POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF
CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE &
EXPERTISE IN ACCORDANCE WITH ACCEPTED
MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE
GUIDELINES

MILLIMAN CARE GUIDELINES

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES X**

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY
ASSURANCE & PRACTICE PARAMETERS

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL
LITERATURE

(PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID,
OUTCOME FOCUSED GUIDELINES

(PROVIDE DESCRIPTION)