Clear Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 CR
Austin, TX 78731
Phone: (512) 879-6370
Fax: (512) 572-0836
Email: @cri-iro.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 Overtuned (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 is a X who was injured on X. The biomechanics of the injury is reportedly described as X. The diagnosis was lumbar radiculopathy (X), lumbar back pain (X), essential hypertension (I10) and overweight (X).On X, X, MD evaluated X for an office visit regarding lumbar spine pain. X had been symptomatic for X months since the date of injury. A X had been ordered but not yet performed. X had been to X visits of physical therapy. X had recurrence of leg pain on the left. X was working with restrictions. On examination, X weight was 280.2 pounds and body mass index (BMI) of 41.53 kg/m2. Right lower extremity strength was X. Left ankle dorsiflexion strength was X and left ankle plantarflexion strength was X. A positive straight leg raise test on the left reproduced sharp pain in the left buttocks and low back, with pain felt at about X degrees. X leaned to the right while sitting on the exam table. There was pain with lumbar spine flexion. No hyperreflexia or clonus was observed. X was a candidate for X. It was okay to restart X, as X had only had X visits. X was a possible surgical candidate. X recommended a X. An MRI of lumbar spine dated X revealed X. A X left paracentral protrusion at X. Annular fissure was seen in the protrusion. There was no lumbar compression fracture or spondylolisthesis seen. Treatment to date included X on X, and activity restrictions / modifications. Per a utilization review adverse determination letter dated X by X, MD, the request for a X was denied. Rationale: “The records do not note sustained reduction of pain or improvement in function for a duration of X weeks.” “ODG states that X in patient with good response to initial injection, is indicated by documentation of sustained improvement of pain or function of X percent, as measured from baseline, for X weeks after X and pain or deterioration in function since X. In this case, the claimant has had prior

X an X. The records do not note sustained reduction of pain or improvement in function for a duration of X weeks, Considering the lack of positive outcome from X, the request for X is not medically necessary. “Per a reconsideration / utilization review adverse determination letter dated X, by X, MD, the request for a X was denied. Rationale: “In this case, the records do not document evidence of sustained improvement of pain or function of X percent for X weeks after X on X as required by evidence-based guidelines to X.” “ODG states that X in patient with good response to X, is indicated by documentation of sustained improvement of pain or function of X percent, as measured from baseline, for X weeks after X and pain or deterioration in function since X. In this case, the records do not document evidence of sustained improvement of pain or function of X percent for X weeks after X on X as required by evidence-based guideline to X. As such, the request for X is not medically necessary. “Based on the submitted documentation, the requested X is not medically necessary. The submitted medical records do not demonstrate that the patient received at least X relief from the X for a minimum of X weeks. Thus, medical necessity cannot be established for a X. No new information was 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:

Based on the submitted documentation, the requested X is not medically necessary. The submitted medical records do not demonstrate that the patient received at least X relief from the prior injection for a minimum of X weeks. Thus, medical necessity cannot be established for a X. No new information was 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:

- ☐ **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)**