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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

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 possible painful lumbar hardware; herniated lumbar disc with radiculopathy; status post X on X; and status X.

X, MD saw X in follow-up on X, for the chief complaint of low back pain and bilateral leg pain. X was status X. Preoperative symptoms had resolved. However, on the X visit, X reported that for the prior month, X had increased low back pain with radiation to the bilateral legs. X had bilateral burning in the legs that kept X up at night. X had to get up and walk around. The pain levels were up to X at times. X took X which helped. X denied any X. Since X visit, X complained of pain in the low back described as a dull ache. X had X. X was working X. MRI scan of the lumbar spine dated X was reviewed and revealed a X. X changes were seen at X. At the time of that visit, X continued to have chronic low back pain. X was approved for a X, which had been scheduled for X. On examination, X was tender over the X. X Straight leg raise was X. Patrick's test was X. Lumbar range of motion revealed forward flexion of X degrees, extension X degrees producing pain. Facet signs were X. The assessment was possible painful X. X was refilled. X was prescribed in the interim. X would undergo a X. X was X. On X, X was evaluated by Dr. X, for complaints of left lower back and leg pain rated X and right lower back and leg pain rated X. X stated the lower back and legs continued to have continuous pain and pain control was more difficult. Per a chart note, it was noted that X recently underwent a X, that gave X improvement in X pain. X would like to proceed with a X.

An MRI of the lumbar spine dated X, demonstrated X. There was X. X at X was noted X. There was X. There was X. X were noted at X. X was noted at X. There was X. X was seen at X. There was X.

Treatment to date included X, _____

Per a utilization review adverse determination letter dated X, the request X was

denied by X., MD. Rationale: "Per ODG by MCG, "Not recommended as a routine procedure for X." ODG by MCG does not address length of stay for X. Per X, "Hospital length of stay averaged X day for the group. Hospital stay averaged only X hospital days for the patients in whom X." In this case, the claimant complains of increased low back pain with radiation to the bilateral legs. The claimant is status post a X on X. The claimant has X on X, which gave the claimant X improvement. Physical examination reveals there is X. There is a X Patrick's test noted, bilaterally. There is also a X. The MRI of the lumbar spine dated X shows at X. There is also X. Based on the guidelines, X is not recommended as a routine procedure and should only be considered in the presence of X. While the claimant reports ongoing low back pain and demonstrated improvement with a prior X. Additionally, the documentation does not confirm that X. Therefore, the request for X is not medically necessary."

In a letter of appeal dated X, Dr. X documented that X was under X care at the time for an on-the-job injury on X. X was status X on X and did well. Preoperative symptoms had resolved. However, X had developed pain over X hardware. X underwent a X. X pain generator was the X. As the X was giving X pain, Dr. X had recommended removal of X, but this had been denied, and X would like to appeal this denial as X would benefit from the proposed surgery.

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "The request is not medically necessary. This is an appeal of a previous denial which noted there is no documented evidence of X. Additionally, the documentation does not confirm that X. The current ODG does not recommend X. Exceptions include X. In review of the available records, there is no evidence of X. There are no imaging reports for the X. The records did not include a X. I spoke with Dr. X on X. Per our discussion, X indicated that the claimant had X improvement from the X. Additional supporting records would be faxed for review. At the time of submission, no additional records were received for review that would support altering the determination. Therefore, X is not medically necessary."

The requested procedure is not medically necessary. While the claimant reports ongoing low back pain and demonstrated improvement with a X, there is no documented evidence of X. Additionally, the documentation does not confirm

that X. There are X. 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 procedure is not medically necessary. While the claimant reports ongoing low back pain and X. Additionally, the documentation does not confirm that X. There are no imaging reports for the X. 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