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Notice of Independent Review Decision
Amendment X
Amendment X

IRO REVIEWER REPORT

Date: X;Amendment 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 at work on X. X reported X was on X knees inside X. The diagnosis was strain of muscle, fascia and tendon of lower back (X). X underwent a functional capacity evaluation (FCE) by Dr. X on X. X passed the X. Further, the test results could be considered valid and reliable and could be used for medical and vocational planning. X occupational demand as a X. According to the results of the evaluation, X was, at that time, performing at Sedentary PDL, which indicated a moderate functional deficit. X was evaluated by X, DO, on X, for lower back pain and right lower extremity pain related to X Workers' Compensation injury. X did not have pain prior to this injury. X continued to complain of low back pain with radiating pain into the bilateral lower extremities, right greater than left. X was still pending X. X had X on X with X relief. The ongoing pain level was X, best X, and worse X. The pain was located in the lower back, and was described as aching, burning, pins and needles, sharp / stabbing, shooting, was constant, and radiated into the right lower extremity. It was aggravated by bending, lifting, sitting, standing, twisting, and walking and alleviated by medication and rest. The X. Examination noted an X. Lumbar spine examination revealed X. X examination revealed X. The MRI of the lumbar spine from X was reviewed. The diagnosis was strain of muscle, fascia and tendon of lower back, initial encounter (X). Dr. X noted X reported pain in the lower back, that was constant. Additionally, X reported pain that radiated to the right lower extremity. X reported that X symptoms started approximately X months ago X. Since then, X reported progressively worsening symptoms. X was currently taking X. X reported moderate relief with this medication regimen. X had undergone X. - X sessions and had tried and failed at least X months of X. X had not undergone anything else besides X. X had not tried X. X had right radicular signs and symptoms with X. It helped X activities of daily living, mobility, and X was able to take less medication. X MRI clearly stated that X had X. Also clinically, X exam on X showed X. Dr. X noted there was subjective and objective evidence on MRI and physical examination. X was appealed. Repeat X was denied. It was noted that pain was mainly X, with no radicular pain since the X had taken care of it. The pain was now reported as X and shown on imaging as

being X of pain. X was X. It was hard to walk, stand, and sit for a long time. X was currently in X. X had X. X was ordered. The radicular pain was more on X. They would consider X. X was increased. X were continued per treating doctor. X was discontinued. An MRI of the lumbar spine dated X, demonstrated X. Clinical correlation was required for findings of X. Treatment to date included X. Per a utilization review adverse determination letter and a peer review report dated X, the request for X was denied by X, MD. Rationale: "Per ODG by X. In this case, based on the provided documentation, the patient was seen for complaints of pain in the low back. The physical examination of the lumbar spine revealed X. X tenderness bilaterally. X mediated pain. Treatment history includes X on X with reports of X. An MRI of the lumbar spine report performed on X, revealed an X. However, the request not supported by guidelines criteria which indicates need of suspected X pain to be evident for at least X months. Additionally, the recent treatment does indicate X but does not discuss the duration of X. As such, medical necessity has not been established. Therefore, the request for X is not certified. "Per a reconsideration review adverse determination letter and a peer review report dated X, the appeal request for X, was denied by X, MD. Rationale: "ODG by X." The previous utilization review on X was non-certified, stating the request was not supported by the guidelines criteria. This indicates the need for suspected X. Additionally, the recent treatment does indicate X. Based on the records reviewed, this patient has X. The patient has X. Treatment provided includes X. The patient has a pain disorder associated with X. The patient has significant functional limitations and requires assistance with regular active disability living. Office visit note dated X physical examination showed there is X. In this case, the request for a X would be reasonable and supported by medical treatment guidelines. The patient has X. The patient has X. However, there is no documentation that the patient has X. Modification of the requested service is X. Therefore, the request for X is upheld and non-certified. "Based on the clinical information provided, the request for X: X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter and a peer review report dated X, the request for X was denied by X, MD. Rationale: "Per ODG by X. In this case, based on the provided documentation, the patient was seen for complaints of pain in the low back. The physical examination of the lumbar spine revealed X. X tenderness bilaterally. X mediated pain. Treatment history includes X. An MRI of the lumbar spine report performed on X, revealed an X. However, the request not supported by guidelines

criteria which indicates need of suspected X. Additionally, X recent treatment does indicate X. As such, medical necessity has not been established. Therefore, the request for X is not certified." Per a reconsideration review adverse determination letter and a peer review report dated X, the appeal request for X, was denied by X, MD. Rationale: "ODG by X. ODG Criteria X." The previous utilization review on X was non-certified, stating the request was not supported by the guidelines criteria. This indicates the need for X. Additionally, the recent treatment does indicate X. Based on the records reviewed, this patient has X. The patient has X. Treatment provided includes X. The patient has a pain disorder associated with X. The patient has significant functional limitations and requires assistance with regular active disability living. Office visit note dated X physical examination showed there is X. In this case, the request for a X would be reasonable and supported by medical treatment guidelines. The patient has X. The patient has X. However, there is no documentation that the patient has X. Modification of the requested service is X. Therefore, the request for X is upheld and non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that the patient underwent designated doctor evaluation on X. Although the actual report is not submitted for review, it is reported that the patient was deemed to be at maximum medical improvement and given a X impairment rating. Also, there is no indication that the patient presents with 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 and a peer review report dated X, the request for X was denied by X, MD. Rationale: "Per ODG by X. X. In this case, based on the provided documentation, the patient was seen for complaints of pain in the low back. The physical examination of the lumbar spine revealed X. X tenderness bilaterally. X mediated pain. Treatment history includes X. An MRI of the lumbar spine report performed on X, revealed an X. However, the request

not supported by guidelines criteria which indicates need of suspected X. Additionally, X recent treatment does indicate X. As such, medical necessity has not been established. Therefore, the request for X is not certified." Per a reconsideration review adverse determination letter and a peer review report dated X, the appeal request for X, was denied by X, MD. Rationale: "ODG by X." The previous utilization review on X was non-certified, stating the request was not supported by the guidelines criteria. This indicates the need for suspected X. Additionally, the recent treatment does indicate X. Based on the records reviewed, this patient has X. The patient has X. Treatment provided includes X. The patient has a pain disorder associated with X. The patient has significant functional limitations and requires assistance with regular active disability living. Office visit note dated X physical examination showed there is X. In this case, the request for a X. The patient has X. The patient has X. However, there is no documentation that the patient has X. Modification of the requested service is X. Therefore, the request for X is upheld and non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that the patient underwent designated doctor evaluation on X. Although the actual report is not submitted for review, it is reported that the patient was deemed to be at maximum medical improvement and given a X impairment rating. Also, there is no indication that the patient presents with X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is not medically necessary and non-certified

Non-Certified

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)