Independent Resolutions Inc.
An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (682) 238-4977
Fax: (888) 299-0415
Email: @independentresolutions.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 Overturned Agree in part/Disagree in part

☒ Upheld Agree

Independent Resolutions Inc.

Notice of Independent Review Decision

Case Number: X Date of Notice: X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

· X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured at work on X, when X was involved in a X. X was X. The diagnosis was other intervertebral disc displacement, lumbar region (X).

On X, X was seen by X, MD / X, MD for follow-up evaluation of low back pain that was X, since the last X years. It had worsened after the X. At the time, the quality of pain was aching, stabbing, throbbing, and constant. Regarding severity, X rated the worst pain as X. The pain was aggravated by coughing, sneezing, or straining (Valsalva). It worsened with extension and worsened when standing. The pain woke X from sleep at night (after a day of activity). Going from sit to stand aggravated it. Nothing helped relieve the pain. Associated symptoms included radiation down the leg (walking distance had been limited to X block before stop and rest). X had an MRI study done earlier that day, which showed X. X had X. X had undergone X. Lumbar spine active range of motion showed flexion was X degrees and extension X degrees with pain. Lateral flexion and rotation were X was noted. Passive range of motion showed flexion was X degrees and extension X degrees. Lateral flexion and rotation were X, was noted. Plantar reflex was absent, X. The assessment was X. Treatment plan was to proceed with X. Dr. X wrote that X recommended X at that time as X seemed still symptomatic

despite conservative measures. A X.

An MRI of lumbar spine dated X, revealed X. There was X seen. At the X.

Treatment to date included X.

Per a Peer Review Report dated X, and a utilization review dated X, the request for X - Dr. X, and X, was denied by X, MD. Rationale for denial of X - Dr. X: "The request is not medically necessary. The records did not document X. No X records for the claimant were included for review detailing response and lack of progress with treatment. No recent X were detailed. The current evaluations of the claimant also X. Therefore X- Dr. X is not medically necessary. Rationale for denial of X: "The request is not medically necessary. The requested X is not supported; therefore, this request is not applicable."

Per a Peer Review Report dated X, and a utilization review adverse determination letter dated X, the request for X, was denied by X, MD. Rationale for denial of X: "The request is not medically necessary. The provided records did not document X. No X records X. No recent X were detailed. The current lumbar MRI report found X. The current evaluations of the claimant also X. Given these issues, which do not meet guideline recommendations, this reviewer cannot recommend certification for the X request. As the X request is not indicated, there would be X. Additionally, ODG would not support use of X. Therefore, the request for the X is not medically necessary. Rationale for denial of X: "The request is not medically necessary. As the X request is not indicated, there would be no requirement for a X. Further, ODG would

not support the use of a X. Therefore, the request is not medically necessary." Per an addendum dated X, Dr. X documented a peer to peer call with no change in determination, indicating, "I spoke with Dr. X on X. Per our discussion, we reviewed the guideline recommendations for the requests. We also reviewed the lack of supporting clinical findings on exam and imaging. Additional supporting documentation would be submitted for review. At the time of submission, an additional X pages of records were received for review that included the previously reviewed lumbar MRI report dated X. There were X included from X. The previously reviewed clinical report dated X was also included. No other information was provided that would support altering the determination."

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 for denial of X: "The requested X procedure is not medically necessary. The submitted magnetic resonance imaging (MRI) report dated X does X. In fact, there is X. Thus, the guidelines have not been met for the requested procedure. Therefore, the appeal request for X is non-certified and upheld." Rationale for denial of X: "As the X procedure is not medically necessary, the ancillary requests are not indicated. Therefore, the appeal request for X is non-certified and upheld."

In a letter dated X, X, MD documented that X had a minimum of X weeks of physician directed X within the prior X months without any improvement of X symptoms. X had also tried X.

In review of the clinical findings, there was no imaging evidence of X.

There were also limited exam findings consistent with X. As there is no indication for X, none of the additional requests would be needed. Therefore, it is this reviewer's opinion that the services in dispute: X is not medically necessary and the prior denials are upheld. X are not medically necessary and non-certified.

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

In review of the clinical findings, there was X. There were also limited exam findings consistent with X. As there is no indication for X, none of the additional requests would be needed. Therefore, it is this reviewer's opinion that the services in dispute: X is not medically necessary and the prior denials are upheld. X are 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:

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

Independent Resolutions Inc.

Notice of Independent Review Decision

Case Number: X Date of Notice: X

☐ 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