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***Notice of Independent Review Decision***  
***Amendment X***

**IRO REVIEWER REPORT**

**Date:** 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

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

X

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

X who was injured on X. The biomechanics of the injury was not included in the provided records. The diagnoses were strain of muscle, fascia and tendon of lower back and radiculopathy of lumbar region.

On X, X was seen by X, MD for low back pain. The pain had been present since X and occurred after a work related injury. Pain was rated as X and described as sharp, burning with co-morbid neurogenic claudication symptoms to the bilateral lower extremities (BLE). Aggravating factors were bending, walking and lifting. X had a history of X with Dr. X. X had tried X. X had an ongoing denial from X workers' compensation insurance. X stated that X continued to have pain in X left lower back, which X described as a sharp pain. X reported pain down the anterior aspect of X right leg and pain down the posterior aspect of left leg. X described the entire right foot, especially the outside, as numb, but could feel the big toe, as well as left lateral foot numbness. X continued to struggle with severe debilitating pain into X low back when stepping of curbs or going down the stairs. X reported dragging of X right foot. X also reported bowel and bladder retention issues that had worsened and remained constant. It was not incontinence, but a lack of urge. Examination showed X offloaded left side when sitting due to pain. Fortin finger test, thigh thrust test and Faber test were X on left side. Distraction test was also X. X walked with slow stiff gait. X was able to toe walk and heel walk with difficulty. Review of MRI of the lumbar spine showed X. No X was noted. There was X. Degenerative disc disease (DDD) was most severe at X. Review of CT scan of the lumbar spine showed X. At the point, X continued to have debilitating pain in X low back. Based on previous imaging and X, Dr. X continued to recommend X as an option for treatment to restore X functional status and return to work.

X was evaluated by X, MD on X for low back pain. X had ongoing denial from X workers' compensation insurance. Pain was still rated as X. X stated that X had pain in X left side lower back, which X described as a sharp pain. X reported stepping down from stairs or curbs caused severe debilitating pain into X low

back. X stated that X had bilateral lower extremity (BLE) pain, right leg worse than left. Right foot was numb and X had numbness in X left small toe. X reported a dragging of X right foot. Examination showed X offloaded left side lower back due to pain. Thigh thrust test and FABER test were X on the left side. Distraction test was X. At the point, X continued to have debilitating pain in X low back. Based on previous imaging and X, Dr. X continued to recommend X as an option for treatment to restore X functional status and return to work.

Treatment to date included X.

Per a Peer Review Report dated X, the request for X was denied by X, MD. Rationale: "The records did not document failure of non-operative measures for the claimant. The claimant was discharged from X. No more recent X records for the claimant were included for review detailing response and lack of progress with treatment. No recent prescription medications for pain such as X were detailed. Review of the prior lumbar CT report noted X. ODG does not recommend X. A current clinical evaluation of the claimant was also not included for review. The last evaluation was more than X months old and is out of date. Therefore, the request for the X is not medically necessary."

Per a Peer Review Report dated X, the appeal request for X was denied by X, MD. Rationale: "This is an appeal of a previous denial which noted. "The records did not document failure of non-operative measures for the claimant. The claimant was discharged from X. No more recent X records for the claimant were included for review detailing response and lack of progress with treatment. No recent prescription medications for pain such as X were detailed. Review of the prior lumbar CT report noted X. ODG does not recommend X. A current clinical evaluation of the claimant was also not included for review." The available records do not address the previous reviewer's concerns. The claimant was not X. No recent prescription medications for pain to include X were detailed. ODG does not recommend X. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request.

Therefore, the request for the X is not medically necessary." The requested X is not medically necessary. The submitted medical records indicate that the claimant has X. The records do not reflect that there is X. The records reflect back

pain only. The actual imaging reports were submitted for review. A bone mineral density test has also not been provided. The guidelines do not recommend 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:**

Therefore, the request for the APPEAL X is not medically necessary.” The requested X is not medically necessary. The submitted medical records indicate that the claimant has X. The records do not reflect that there is an X. The records reflect back pain only. The actual imaging reports were submitted for review. A bone mineral density test has also not been provided. The guidelines do not recommend X. No new information has been provided which would overturn the previous denials. 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:**

- 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