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Austin, TX 78758 **IRO Certificate #**

Notice of Independent Review Decision

DATE OF REVIEW: X

IRO CASE NO. 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:

Upheld **(Agree) X**

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X
PATIENT CLINICAL HISTORY SUMMARY

This is a X who sustained a work related injury on X. X was diagnosed with X through X transverse process fractures and right iliopsoas contusion via CT scan. Updated CT scan of the lumbar spine on X showed X. Rib xray on X showed X. Updated MRI of the lumbar spine on X showed X. Imaging studies were not included in this review. X was prescribed X and X and returned to work without restrictions. A letter was submitted by Dr X on X noting patient presented with lower back pain, with decreased range of motion and pain with movement of lumbar spine in all planes and examination showing weakness of the lumbar extensor muscles. It was determined X would benefit from the X. Initial denial was due to no sufficient objective quantifiable findings of lumbar extensor weakness and no clear justification provided for why this X was needed instead of lower tech alternatives. Appeal letter counters that the denial did not identify a clinically appropriate lower tech alternative.

The requested service, **"X" is not medically necessary..**

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

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continuation)

Opinion: I agree with the benefit company's decision to deny the requested service.

Rationale: This review pertains to the need for a X. The patient was returned to work with no restrictions. X was prescribed. It is unclear if X was done but there does not appear to be any documentation of why X.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA

OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

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

Disclaimer:
X opinions rendered in this case are the opinions of this evaluator. This evaluation has been conducted on the basis of the medical documentation as provided with the assumption that the material is true, complete, and correct. If more information becomes available at a later date, then additional service, reports, or reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. The opinion is based on a clinical assessment from the documentation provided