

True Resolutions Inc.

An Independent Review Organization

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Date: 11/19/2018 XX:38:XX PM CST

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Orthopaedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|--------------------------------|
| <input type="checkbox"/> Overturned | Disagree |
| <input type="checkbox"/> Partially Overturned | Agree in part/Disagree in part |
| <input checked="" type="checkbox"/> Upheld | Agree |

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX who was diagnosed with XX of the XX XX, and XX XX XX. XXXX sustained a XXXX, resulting in XX of the XX XX and XX XX pain since then. XXXX was seen by XXXX for a follow-up on XX XX and XX. The pain was located in the XX part of the XX XX. It was mild and aggravated by XX. It was alleviated by XX, elevation, limited weightbearing, XX / XX therapy, XXXX, prior surgery, and home exercise program. The associated symptoms included XX. The examination of the XX XX revealed XX. There was no pain noted with the XX moving XX. The XX XX examination also revealed XX. XXXX was to continue to either work XX in a standing position or perform unlimited sedentary work. The diagnoses were XX of the XX XX, XX XX XX, and type XX XX XX without complications. XXXX had seen a designated doctor and had gone to XX / XX in XXXX. It was recommended that XXXX be submitted for an IRO (Independent Review Organization). Per a letter dated XXXX, the XX was denied due to lack of XX therapy notes that were included in the initial documentation sent. Rationale: "Due to the protracted case thus far but with prior XX therapy progress, and thus likely continued and further success." XX. Per the office note dated XXXX, x-ray of the XX revealed no fracture or dislocation. The joint spaces were well preserved and normal alignment was noted. The treatment to date consisted of XX XX XX with XX XX release on XXXX, rest, limited XX, XX therapy (helped significantly), medications including XXXX (did not help), XX XX (XX-XX XX) (did not help), home exercise program, and use of crutches. Per an Initial Adverse Determination letter dated XXXX and the peer review report dated XXXX by XXXX, the request was noncertified. Rationale: "The available documentation indicates that the claimant has a work-

related injury from XXXX to the XX. The claimant is status post XX XX XX and XX XX XX with Release from XXXX. It is assumed the claimant has had XX therapy; however, the results, frequency, and duration of those visits were not provided. The examination demonstrated XX XX XX and the XX, and limited range of motion (ROM). It is not clear how XX will benefit the claimant. The provider has not provided any rationale to support this request. ODG Recommends work conditioning as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. There are no specifics reported regarding previous conservative therapies nor any goals related with this request. Therefore, based on the lack of submitted documentation and guideline support, I recommend noncertification for this request for XX XX x wk. x XX wks.” Per a Reconsideration Review Adverse Determination letter dated XXXX, the request was upheld. Per a Peer Review report dated XXXX, the request was noncertified. Rationale: “Within the associated medical file, there is documentation of the XXXX UR Determination identifying that an adverse determination was rendered due to a lack of documentation of the results, frequency, and duration of previous XX therapy visits; previous conservative therapies nor any goals related with this request; as well as any rationale to support this request; and the XXXX UR Determination identifying that an adverse determination was rendered due to a lack of documentation of a rationale to support this request, that the patient requires additional series of intensive XX therapy visits beyond the normal course of XX therapy, primarily for exercise training supervision, as well as the number of previous Work Conditioning visits to determine if the recommended XX visits have been exceeded or will be exceeded with the current request. In addition, there is documentation that the patient had prior XX therapy treatments, as well as remaining functional deficits and functional goals. However, despite documentation of the XXXX letter (from Painter, PT, DPT) identifying that the rationale for the request is due to the protracted case thus far but with previous XX therapy (XX) progress, and thus likely continued and further success; and that the patient will be instructed in an intensive return to work program in our work conditioning program unlike typical XX therapy (XX); there remains no documentation (from the treating/requesting physician (XXXX)) of a rationale to support this request. As such, there remains no documentation (from the treating/requesting physician (XXXX)) that the patient requires additional series of intensive XX therapy visits beyond the normal course of XX therapy, primarily for exercise training/supervision. In addition, there remains documentation (from XXXX) that the XXXX is for continuation of XX. As such, the previous adverse determinations concern for a lack of documentation of the number of previous XX visits to determine if the recommended XX visits have been exceeded or will be exceeded with the current request; has not been addressed. Therefore, I am recommending non-certifying the request for second appeal: XX” Per an Adverse Determination letter for second appeal dated XXXX, a reconsideration request for XX was denied. Rationale: “Within the associated medical file, there is documentation of the XXXX UR Determination identifying that an adverse determination was rendered due to a lack of documentation of the results, frequency, and duration of previous XX therapy visits; previous conservative therapies nor any goals related with this request; as well as any rationale to support this request; and the XXXX UR Determination identifying that an adverse determination was rendered due to a lack of documentation of a rationale to support this request, that the patient requires additional series of intensive XX therapy visits beyond the normal course of XX therapy, primarily for exercise training supervision, as well as the number of previous XX visits to determine if the recommended XX visits have been exceeded or will be exceeded with the current request. In addition, there is documentation that the patient had prior XX therapy treatments, as well as

remaining functional deficits and functional goals. However, despite documentation of the XXXX Letter (from XXXX) identifying that the rationale for the request is due to the protracted case thus far but with previous XX therapy (XX) progress, and thus likely continued and further success; and that the patient will be instructed in an intensive return to work program in our work conditioning program unlike typical XX therapy (XX); there remains no documentation (from the treating/requesting physician (XXXX)) of a rationale to support this request. As such, there remains no documentation (from the treating/requesting physician (XXXX)) that the patient requires additional series of intensive XX therapy visits beyond the normal course of XX therapy, primarily for exercise training/supervision. In addition, there remains documentation (from XXXX) that the XXXX Plan is for continuation of XX. As such, the previous adverse determinations concern for a lack of documentation of the number of previous XX visits to determine if the recommended XX visits have been exceeded or will be exceeded with the current request; has not been addressed. Therefore, I am recommending non-certifying the request for second appeal: XX”

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

XX The provided documentation reveals a history of a XX XX XX with XX XX release on XXXX. There is evidence of persistent functional XX. However, there is also evidence of previous XX. The number of XX visits completed to date is not documented. Furthermore, as the current request is for XX sessions of XX and given that there has been at least some previous XX, the current request exceeds the guideline recommendation.

As such, medical necessity has not been established and the decision is upheld.

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 KNOWLEDGBASE
- ☐ 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
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL