True Resolutions Inc.

Notice of Independent Review Decision

Case Number: Date of Notice: 7/22/2019 4:30:59 PM CST

True Resolutions Inc.
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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records –X
• Notification of Adverse Determination –X
• Notification of Reconsideration Adverse Determination –X
• Diagnostic Data –X

PATIENT CLINICAL HISTORY [SUMMARY]: X who sustained an injury on X. X was cleaning out the X. The ongoing diagnoses included other X, unspecified, X region; and X, X region. X visited X, PA-C / X, MD on X, X presented for X symptom of X pain. X had lacking X and having trouble with X in terms of X of the X. X had some slight symptoms in the X, but very mild compared to those on the X, which were significantly limiting X activities of daily living. X also complained of X pain radiating down to the X. On examination, X was more restricted on rotation to the X with increased X and somewhat exacerbated with X and better with X. There was X graded at X. X was X. X had increased X pain with abduction to roughly X degrees and was limited to going further due to the severity of pain. There was slightly exaggerated X. X-rays of the X showed X. The treatment plan included proceeding with X, if significant benefit and return to function was not accomplished with the X treatments. On X, X complained of X. X presented to discuss X. X had X. On X, X presented for X pain. X complained of pain in X X into X X. X reported pain radiating down X X through X and mainly into the X. On examination, X had strong X. X were X. The reflexes at the X were absent. The reflexes on the X. X did have an X sign of X. An MRI of the X dated X showed X seen at the X levels with mild X plain x-rays with oblique views might be obtained as clinically indicated to assess X levels. There was a X level with X. There was

associated moderate narrowing of the X. The treatment to date included medications (X (no relief). Per a Utilization Review Decision letter dated X, the request for X was denied by X, DO. Rationale: "The claimant initially described X pain before identifying any X symptoms. There were no prior X imaging studies submitted for review ruling out any potential X. The claimant had been attending X according to the provided records; however, no therapy reports were submitted for review detailing a X therapy. The records also did not include a recent in-depth evaluation of the claimant demonstrating any ongoing X to support proceeding with X. Per a Reconsideration Adverse Determination letter dated X, the prior denial was X by X, MD. Rationale: "The presented objective findings were limited in order to necessitate the need for X. The actual X was still not presented. Furthermore, the patient was reported X. There should be a X program. There were no exceptional factors noted. The prior non-certification is X. Furthermore, during the peer discussion with Dr. X, the provider stated that the patient has no strong X. There is a strong X. Regarding sensory change, there is X. MRI results from X were read out. There is a X. The MRI report was requested. After the peer discussion, the patient does not meet the criteria per guidelines. Patient has strong X and history. Patient would need to be evaluated with X levels prior to any X due to potential complications and X of XX due to X use. Physical findings do not directly correlate to MRI images. Therefore, the request is not supported."

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

The claimant has been followed for complaints of X pain with X present in the X. The claimant also reported X pain. There was no documented X. The claimant was treatment with X as well as X. The claimant did receive an evaluation for X regarding X pain. There were no physical therapy records for the X region demonstrating X to progress or that the claimant reached a X. While there is evidence to support a X, without documentation regarding X measures; it is this reviewer's opinion that medical necessity is not established.

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Given the documentation available, the requested service(s) is considered not medically necessary and therefore the request is X.

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

☐ 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