True Resolutions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 1/28/2019 3:46:31 PM CST

True Resolutions Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #624
Mansfield, TX 76063
Phone: (512) 501-3856
Fax: (888) 415-9586
Email: manager@trueresolutionsiro.com

IRO REVIEWER REPORT

Date: 1/28/2019 3:46:31 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Diagnostic XX XX XX/XX on the XX X XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Pain Medicine, Physical Medicine & Rehab

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

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX-year-old XX with a date of injury XX. XX was trying to XX. XX was XX. XX was diagnosed with XX, XX and XX of XX XX, initial encounter (XX.XX) and sprain of XX of XX XX, initial encounter (XX.XX).On XX, XX. XX was evaluated by XX for the chief complaint of XX XX pain and XX XX pain. MRI of the XX XX was positive for XX XX at XX-XX. XX was able to stand / sit / walk less than XX. XX rated XX pain at XX/10. XX reported XX pain as a constant XX, XX pain, XX, XX, XX, and XX. Nothing would make the pain feel better at the time. Physical examination was unchanged from prior examination. On XX office visit, physical examination showed pain on rotation of the XX XX. There was XX tenderness in the XX. There was pain in the XX XX at XX-XX XX. XX XX examination showed poor toe walking and poor heel walking on the XX. XX was positive on XX. It also showed sensory deficits in the XX XX-XX XX. An MRI of the XX XX dated XX documented moderate XX XX XX at XX-XX with resulting moderate

compression of the XX XX XX roots. There was subtle XX XX XX of XX. The magnetic resonance imaging of the XX XX dated XX documented XX XX XX measuring approximately XX XX at XX-XX creating mild XX lateral recess XX without XX XX. There was subtle XX XX of XX. An MRI imaging of the XX XX was performed on XX and demonstrated a XX XX XX of XX XX at XX-XX creating XX lateral recessed XX with subtle XX XX at XX. An MRI of the XX XX was performed on XX. This study demonstrated moderate XX XX XX at XX-XX with moderate compression of the XX XX nerve roots and possible XX XX XX XX. A subtle XX XX XX was noted at XX. Treatment to date consisted of rest, hot baths with XX XX, physical therapy, group therapy, massage therapy, pain management program, and medications. XX ongoing medication was XX. Per a Utilization Review Peer Reviewers Response XX dated XX, the request for diagnostic XX XX at XX-XX on the XX times one and XX facet block XX-XX level medial branch, bilateral times one were not certified. Rationale: "Based on the submitted records, the patient appears to have both XX XX pain and XX XX pain with XX symptoms to the XX XX. Past treatments include medications and a course of physical therapy without resolution of symptoms. Objective exam was notable for pain in the XX XX with XX rotation and pain in the XX XX-XX XX XX joints. XX examination was positive for poor heel walking, positive XX XX, and sensory deficits in the XX XX-XX XX. An MRI report showed XX XX XX XX at XX-XX along with a large XX XX at the XX-XX level impinging on the XX XX XX root. The treating providers are now requesting to perform a XX XX XX and a XX-XX XX XX joint XX XX XX for diagnostic purposes. ODG XX XX states the following regarding diagnostic XX epidural injections: XX Per a Utilization Review Peer Reviewer's Response dated XX, the request for appeal for diagnostic XX XX XX-XX on the XX XX was not certified. Rationale: "XX. In this case, the history and clinical findings were on the XX but MRI imaging suggested XX-sided XX XX impingement. The findings did not correlate. Therefore, in this situation the request was not medically necessary and should be noncertified."

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

Based on the clinical information provided, the request for Diagnostic XX XX at XX-XX on the XX times one and XX XX XX XX-XX level, XX XX of XX XX XX times one is not recommended as medically necessary, and the previous denials are upheld. Per a Utilization Review Peer Reviewers Response XX dated XX, the request for diagnostic XX XX at XX-XX on the XX times one and XX XX XX XX-XX level XX XX, XX times one were not certified. Rationale: "Based on the submitted records, the patient appears to have both XX XX pain and XX XX pain with XX symptoms to the XX XX. Past treatments include medications and a course of physical therapy without resolution of symptoms. Objective exam was notable for pain in the XX XX with XX rotation and pain in the XX XX-XX XX XX joints. XX examination was XX for poor heel walking, positive XX XX, and sensory deficits in the XX XX-XX XX. An MRI report showed XX XX XX disease at XX-XX along with a large XX XX at the XX-XX level impinging on the XX XX XX root. The treating providers are now requesting to perform a XX XX XX and a XX-XX XX XX joint XX XX block for diagnostic purposes. ODG XX XX states the following regarding diagnostic XX XX injections: XX. Given that ODG supports XX XX injections for diagnostic purposes when the imaging studies and the physical signs and symptoms differ, this request for a XX XX XX can be considered appropriate. In regards to the XX XX XX XX blocks, the submitted documents make no mention of whether this procedure will be done for diagnostic or therapeutic purposes. Additionally, if for diagnostic purposes, ODG states that there should be a plan in place to proceed with XX XX, but no mention of XX XX XX is noted in the submitted records. As such, and since a peer-to-peer discussion must take place to modify a request, this request for both a XX XX and XX XX blocks is not appropriate or medically necessary." Per a Utilization Review Peer Reviewer's Response dated XX, the request for appeal for diagnostic XX XX XX XX XX-XX on the XX XX was not certified. Rationale: "The Official Disability Guidelines discusses indications for XX. An XX may be indicated in a situation where the history, neurological exam and diagnostic studies correlated to confirm the presence of a XX at a particular level. In this case, the history and clinical findings were on the XX but MRI imaging suggested XX-sided XX XX impingement. The findings did not correlate. Therefore, in this situation the request was not medically necessary and should be noncertified." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines

note that XX XX injections are not recommended. There is limited research on therapeutic blocks or XX in this region, and the latter procedure (XX) are not recommended. Recent publications on the topic of therapeutic XX injections have not addressed the use of this modality for the XX region. Pain due to XX XX XX is less common in the XX area as there is overall less movement due to the XX to the XX XX. Injection of the XX in this region also presents technical challenge. Additionally, it appears that the patient has recently been participating in a XX XX XX pain management program which indicates a finding that XX levels of care had been exhausted.

Therefore, medical necessity is not established in accordance with current evidence based guidelines and the decision is upheld.

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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