# True Resolutions Inc.

## *Notice of Independent Review Decision*

Case Number: Date of Notice: 6/24/2019 and amended 7/8/2019

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**True Resolutions Inc.**
**An Independent Review Organization**
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**INFORMATION PROVIDED TO THE IRO FOR REVIEW:** • Clinical Records –X
- Utilization Review –X
- Letters –X
- Peer Review Reports –X
- Notification of Adverse Determination –X
- Notification of Reconsideration Adverse Determination –X
- Diagnostic Data –X

**PATIENT CLINICAL HISTORY [SUMMARY]: X** is a X-year-old X with date of injury X. X suffered from a X injury after X. On XX, X was seen by X, PT for improving X pain. There was some pain at the time that X. An initial examination performed on X revealed that X was X with a complaint of X pain and increase with X. X was standing with a X. Slump test was positive greater on the X. Joint mobility was limited on the X level with moderate X greater on the X. Mild X was also noted that wag greater at the X level compared to the X level. Trunk flexion at X level was present with increased pain across the X and X. The X extension was limited at the X. On X, X presented to X, DO for a follow up on the X. X stated that X symptoms had slowly improved. X had run out of medications and X ongoing symptoms included pain and X. On examination, there was X level, X, and severe X pain. X reflexes on the right were X. An MRI of the X dated X revealed a X level with minimal X level, which in conjunction with X could affect the exiting X. There was non-compressive X. Treatment to date consisted of medications (X and X), X,

and X. Per Utilization Review dated X, X, MD denied the request for X level. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced above, this request is non-certified. Clarification is needed if the previously certified central X on X had already been performed. If so, objective efficacy, functional response, and decreased need for pain medications from the prior injection were not clearly established to support the need for a repeat X. Clarification is needed for the indication of the request and how it would affect the patient's clinical outcomes." Per Reconsideration Adverse Determination dated X, X, MD stated that "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Based on the clinical information provided, the appeal request for X is not recommended as medically necessary. The initial request was non-certified noting that clarification is needed if the previously certified X on X had already been performed. If so, objective efficacy, functional response, and decreased need for pain medications from the prior injection were not clearly established to support the need for a repeat. Clinical records indicate that the prior X was canceled because of Dr. X. There is insufficient information to support a change in determination, and the previous non-certification is X. The Official Disability Guidelines require documentation of X on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active X strength, X and X. There is no X documented on X MRI. Therefore, medical necessity is not established in accordance with current evidence-based guidelines."

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

Official Disability Guidelines discusses indications for X. X may be indicated for treatment of a X when symptoms, diagnostic studies, and neurological exam findings correlate to confirm X level. Such findings are not present at this time.

Moreover, the guidelines generally recommend X early in the course of an injury in order to facilitate initial active functional restoration; the benefit of an X in a chronic setting such as currently is less clear.
For these multiple reasons, at this time this request is not medically necessary and 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

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## ODG/LSPINE/ESI Criteria for the use of Epidural steroid injections