True Resolutions Inc.

Notice of Independent Review Decision

Case Number: Date of Notice: 6/10/2019 5:32:18 PM CST

True Resolutions Inc.

An Independent Review Organization
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IRO REVIEWER REPORT

Date: X

IRO CASE 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: Orthopaedic Surgery

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: Clinical Records X,
- Texas Workers' Compensation Work Status Report –X
- Utilization Review –X
- Letters of Medical Necessity X
- Diagnostic Data –X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X -year-old X who sustained an injury on X to X when X and X at X. X was re-injured on X after a X, when X. There was no injury to the X. The diagnoses were other X. X had a history of X

with X. X was seen by X, MD on X for complaints in the X. The pain was described as X rated X at X at its worst. The symptoms were worse with X and X and improved with X. X reported X. There was X since the date of injury. On examination of the X, there was X. The X was restricted secondary to pain. A CT scan of the X dated X showed comminuted X involving the X and the X extending to the X creating a X. An MRI scan of the X dated X revealed X in the X, X within the X, X and X in the X, and X change about the X and X. X of the X dated X and a X dated X were normal. An MRI of the XX XX dated XX showed small amount of fluid in the XX XX joint capsule, and minor X change. X-rays of the X dated X demonstrated X with X healed. The treatment to date included X(helpful), X, and X. Per a utilization review decision letter dated X, the request for X was approved by X, MD. In a letter of medical necessity dated X, Dr. X documented that X had tried X previously with great pain relief. X experienced an increase in abilities with decrease in pain levels.

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

The ODG supports the utilization of X as an option for the management of X pain which is amenable to X treatment. The records available indicate significant improvement in pain control with the utilization of X. Given the chronicity of the symptoms and reported efficacy of the topical XX solution, ongoing use would be reasonable and appropriate. Additionally, there is a documented contraindication to X.

As such, the previous denial should be overturned. Given the documentation available, the requested service(s) is considered medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG, 2019: pain