# 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:** 5/1/2019 7:02:10 PM CST

**IRO CASE #:** XX

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Post appeal request for purchase of XX XX XX post XX XX fusion

**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 |

**PATIENT CLINICAL HISTORY [SUMMARY]:** XX. XX XX is a XX-year-old XX who was injured on XX. XX XX while XX on some XX XX. XX XX on an XX XX XX to keep from XX, and started to have some XX XX pain that worsened the day after the incident. XX was diagnosed with XX XX of the XX region with XX XX (XX.XX). On XX, XX. XX presented to XX XX, II, XX to discuss the MRI results of the XX XX. XX XX radicular symptoms were persistent. XX reported XX XX pain. The pain was rated at 6/10 with radiating symptoms down XX XX XX. The ongoing symptoms remained unchanged in quality and character. On examination of the XX XX, XX had light touch sensation diminished in the XX of the XX. There was tenderness to palpation of the XX XX muscles. The XX joint was tender. There was positive compression, and range of motion (ROM) was abnormal and limited. Straight XX XX raise was positive for XX pain in the XX distribution. Downgoing XX XX were noted. The strength was +3/5 over the XX anterior. XX. XX recommended XX-XX and XX-XX anterior XX interbody fusion with posterior instrumentation. The magnetic resonance imaging (MRI) of the XX XX dated XX documented advanced XX XX disease and facet XX diffusely through the visualized XX XX and XX XX with mild grade I XX XX of XX “to gray” and XX greater than XX. There were multilevel XX canal and XX XX XX with XX XX XX most advanced at XX-XX and with neural XX XX most advanced and high-grade on the XX at XX-XX and most advanced and moderate to severe on the XX at XX-XX. There was no acute pathology identified. The treatment to date included medications (XX

with XX, XX, XX, XX, XX, XX XX), home exercise program (HEP), five sessions of XX therapy, and duty modifications, XX XX-XX XX epidural steroid injection (TFESI) on XX (80% relief for XX to XX days), XX-XX XX epidural steroid injection (70% relief for XX weeks). XX. XX had tried and failed XX months of conservative measures including XX weeks of XX therapy, prescription strength nonsteroidal anti-inflammatory, XX, and selective nerve root block / epidural steroid injections. Per a utilization review decision letter and peer review dated XX, the request for XX XX XX post XX XX fusion was denied by XX, XX. Rationale: "The request for XX-XX and XX-XX anterior XX interbody fusion with Bone Morphogenetic protein (BMP) and XX-XX posterior XX fusion and XX is not certified. Therefore the request for the purchase of XX XX XX (XX) post XX XX fusion is not medically necessary." Per an adverse determination letter and peer review dated XX, the prior denial was upheld by XX XX, XX. Rationale: "There was a previous adverse determination dated XX, regarding the request for purchase of XX XX XX (XX) post XX XX fusion. ODG Low XX (updated XX) - Online Version XX XX, post-operative (fusion) Under study, but given the lack of evidence supporting the use of those devices, a standard XX would be preferred over a custom post-op XX, if any, depending on the experience and expertise of the treating physician. The request for XX and XX-XX anterior XX Interbody XX with XX XX XX (XX) and XX-XX posterior XX fusion and XX with co-surgeon is not certified. Therefore, the request is not medically necessary."

**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 XX XX XX post XX XX fusion XX XX-XX XX, XX-XX control, with rigid anterior and posterior frame/panels, posterior extends from XX junction to XX-XX XX, lateral strength provided by rigid XX frame/panels, produces XX pressure to reduce load on XX discs, includes straps, closures, may include padding, XX straps, XX XX design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review decision letter and peer review dated XX, the request for XX XX XX post XX XX fusion was denied by XX XX, XX. Rationale: "The request for XX-XX and XX-XX anterior XX interbody XX with XX XX XX (XX) and XX-XX posterior XX fusion and XX is not certified. Therefore, the request for the purchase of XX XX XX (XX) post XX XX fusion is not medically necessary." Per an adverse determination letter and peer review dated XX, the prior denial was upheld by XX XX, XX. Rationale: "There was a previous adverse determination dated XX, regarding the request for purchase of XX XX XX (XX) post XX XX fusion. ODG Low XX (updated XX) - Online Version XX XX, post-operative (fusion) Under study, but given the lack of evidence supporting the use of those devices, a standard XX would be preferred over a custom post-op XX, if any, depending on the experience and expertise of the treating physician. The request for XX and XX-XX anterior XX Interbody XX with XX XX XX (XX) and XX-XX posterior XX fusion and XX with co-surgeon is not certified. Therefore, the request is not medically necessary."
There is insufficient information to support a change in determination, and the previous non-certification is upheld.
The submitted clinical records indicate that the request for surgical intervention was non-certified.
Given that the surgery is not medically necessary, likewise the request for postoperative XX XX XX is not medically necessary 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 KNOWLEDGEBASE

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW XX 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