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: @trueresolutionsiro.com

Notice of Independent Review Decision

Amendment x

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: X

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:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X reported that X was on the X and injured X lower X, thoracic X, both X, both X, and left X. The diagnosis was lumbar X, thoracic X, and cervical X. On X, X, MD evaluated X for a work-related injury sustained while working for X. X felt about the same after the X. X had X, and X to the left X, rated X. X made the X. X made it X. X was following the treatment plan, but was X. X had X. X had X which had X. X had an X and other X. On examination, X blood pressure was 162/74 mmHg. Examination of the lumbosacral X revealed X of the lumbosacral X was decreased by X. X had X on the left. X had X bilaterally at X. Examination of the thoracic X revealed thoracic X. X had reached a point in the treatment plan where the determination was to proceed with a X. This decision was based on the complex nature of the injury, how it was impacting X bodily function as well as the fact that they had exhausted all conservative treatment options which included X. On X, X, MD evaluated X for a work-related injury sustained while working for X. X felt about the same. X rated the pain level of X. X had thoracic pain and lumbar pain. X made the pain worse. X on X side made it better. X had no new symptoms. X was following the treatment plan, but was not really helping. X had multiple sessions of X. X had X and X. On examination, X blood pressure was 153/83 mmHg. Musculoskeletal examination revealed X. X of the lumbosacral X was decreased by X. Treatment to date included X. Per a Peer Review dated X, X, MD non-certified the request for X. Rationale: “The injured worker has low X pain and thoracic pain. X noted X to left X. Pain is rated X. X makes pain

worse. X has had X. with no improvement. The X exam of the lumbar X showed decreased X.X. X on the left. X bilaterally at X. The thoracic X exam showed pain in X thoracic area. Thoracic X exam on X showed painful X. X has had a lumbar X. The physical exam findings of the thoracic X does not suggest X, thus the request is not medically necessary." Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The injured worker has low X. X noted X to left X. Pain is rated X. X makes pain worse. X has had X. with no improvement. The X exam of the lumbar X showed decreased X. X. X on the left. X. The thoracic X exam showed pain in X thoracic area. Thoracic X exam on X showed painful X. X has had a lumbar X. The physical exam findings of the thoracic X does not suggest X, thus the request is not medically necessary." Per a Peer Review dated X, X, MD non-certified the request for X. Rationale: "Based on the documentation provided and per the guidelines, the requested X is not recommended in this case. Though the injured worker has a history of continued pain secondary to work-related injury, guidelines does not recommend the requested procedure in the thoracic X. Per the guidelines larger studies are needed to support efficacy and safety. As such, the request is non-authorized in this case." Per an appeal request dated X, X , MD provided a reconsideration request on X for X. Per a reconsideration / utilization review adverse determination letter dated X, X, MD non-certified the request for X. Rationale: "Based on the documentation provided and per the guidelines, the requested X is not recommended in this case. Though the injured worker has a history of continued pain secondary to work-related injury, guidelines does not recommend the requested procedure in the thoracic X. Per the guidelines larger studies are needed to support efficacy and safety. As such, the request is non-authorized in this case." Thoroughly reviewed provided records including provider notes, peer reviews. Agree with peer reviews that patient with X. Possible that has X mediated pain but also has X left X. Per ODG criteria cited by reviewers, X. Regardless of

what criteria being used, patient selection is crucial for success of X. X is not medically necessary and non certified

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

Thoroughly reviewed provided records including provider notes, peer reviews. Agree with peer reviews that patient with X. Possible that has X left X. Per ODG criteria cited by reviewers, X. Regardless of what criteria being used, patient selection is X. X is not medically necessary and non certified

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 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

☐ TMF SCREENING CRITERIA MANUAL