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; Amendment 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 was injured when X hurt X low back. The diagnosis was painful hardware or graft; history of osteomyelitis; chronic pain syndrome; lumbar disc herniation; strain of muscle, fascia and tendon of lower back, initial encounter; lumbar radiculopathy (sciatica); lumbar intervertebral disc without myelopathy; and post-laminectomy syndrome; lumbar. On X, X was seen by X, DO for follow-up regarding X ongoing chronic back and leg pain. Dr. X stated that they did submit a re-conservation to Workers' Compensation since X was denied for a psych evaluation. They did obtain this and sent this for reconsideration. There was supposedly several phone calls made, but they did not receive any phone calls in order to do pre-review. This was denied again. X symptoms were fairly consistent with primary back pain, intermittent leg pain; worse on the left than the right. X had made good recovery from X. X had some treatments done on X shoulders, so generally it was just a Workers' Compensation injury. X had lower back and bilateral leg pain, which was sharp and cramping in nature. X rated the pain at the time a X, with medications X and without medications X. On examination, weight was 270 pounds and BMI was 39.87 kg/m2. The physical examination revealed X was X. There were X seen. The lumbar examination revealed X. The lumbar range of motion (ROM) showed increased X. There was increased X. The strength testing revealed X. The sensation was X. The X test was X. The X was X. The X was X. X was X. The X. Dr. X recommended a X. The X. X had excellent coverage from X trial, but did not receive the same coverage from X permanent. Dr. X

recommended to re-submit this and follow up on the reconsideration and submit this to an IRO if this was not approved. An MRI of lumbar spine dated X revealed X. There was X. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied as not medically necessary. Rationale: “Official Disability Guidelines recommends X. On X, the claimant was seen for continued symptoms of low back pain rated X. Exam low back showed X. There is no noted X. As such, the request for X is non-certified.” On X, an appeal letter by X, Surgery Scheduler in Dr. X office was documented, requesting to reconsider the request of X. X requested a peer-to-peer discussion with the reviewing doctor and noted they had made several attempts to reach the peer doctor but X was never available. Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Documentation indicates that the claimant had a previously successful X. It is unclear why a X. Although, the proposed treatment is different (X. Therefore, this request is not medically necessary.” X is a X who was injured on X. X was injured when X hurt X low back. The diagnosis was painful hardware or graft; history of osteomyelitis; chronic pain syndrome; lumbar disc herniation; strain of muscle, fascia and tendon of lower back, initial encounter; lumbar radiculopathy (sciatica); lumbar intervertebral disc without myelopathy; and post-laminectomy syndrome; lumbar. On X, X was seen by X, DO for follow-up regarding X ongoing chronic back and leg pain. Dr. X stated that they did submit a re-conservation to Workers’ Compensation since X was denied for a psych evaluation. They did obtain this and sent this for reconsideration. There was supposedly several phone calls made, but they did not receive any phone calls in order to do pre-review. This was denied again. X symptoms were fairly consistent with primary back pain, intermittent leg pain; worse on the left than the right. X had made good recovery from X X. X had some treatments done on X shoulders, so generally it was just a Workers’ Compensation injury. X had lower back and bilateral leg pain,

which was sharp and cramping in nature. X rated the pain at the time a X , with medications X and without medications X. On examination, weight was 270 pounds and BMI was 39.87 kg/m2. The physical examination revealed X was X. There were X. The lumbar examination revealed X. The lumbar range of motion (ROM) showed X. There was increased pain with X. The X testing revealed X. The X was intact X. The X test was X. The X was X. The X was X. X was X. The X. Dr. X recommended a X. The X. X had excellent coverage from X trial, but did not receive the same coverage from X permanent. Dr. X recommended to re-submit this and follow up on the reconsideration and submit this to an IRO if this was not approved. An MRI of lumbar spine dated X revealed X. There was X. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied as not medically necessary. Rationale: “Official Disability Guidelines recommends X. On X, the claimant was seen for continued symptoms of low back pain rated X with intermittent leg pain worse on the left than the right. Exam low back showed X. There is no noted X. As such, the request for X is non-certified.” On X, an appeal letter by X , Surgery Scheduler in Dr. X office was documented, requesting to reconsider the request of X. X requested a peer-to-peer discussion with the reviewing doctor and noted they had made several attempts to reach the peer doctor but X was never available. Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Documentation indicates that the claimant had a previously X. It is unclear why a X. Although, the proposed treatment is different X. Therefore, this request is not medically necessary.” X is not medically necessary ands non certified

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

Per a reconsideration review adverse determination letter dated X by X,

MD, the request for X was denied. Rationale: “Documentation indicates that the claimant had a previously X. It is unclear why a X. Although, the proposed treatment is different X. Therefore, this request is not medically necessary.” X is not medically necessary ands 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