**True Resolutions Inc.**
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***Notice of Independent Review Decision***

**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. The biomechanics of the injury were not available in the provided records. The diagnosis per the reconsideration review adverse determination letter dated X was strain of muscle and tendon of unspecified wall of thorax. No office visits or imaging reports were available in the provided medical records. Per a utilization review adverse determination letter dated X, X, MD had nonauthorized medical necessity for X. Rationale: “Official Disability Guidelines do not recommend X. On X, the claimant presented with pain in the X. X pain level was X. Pain radiates with movement to the left. Prior treatments include multiple sessions of X. The thoracic spine examination showed tenderness at the X. Thoracic spine MRI showed an unremarkable result. Guidelines do not recommend X. Pain due to facet joint arthrosis is uncommon in the thoracic spine, where there is far less articular movement due to attachment to the rib cage. X also presents a technical challenge, where recommendation for diagnostic or therapeutic purposes has been precluded by a paucity of research. There are no exceptional clinical findings noted in the medical records that would support going beyond the guideline’s recommendations. As such, the medical necessity has not been established for X. ” Per a reconsideration review adverse determination letter dated X, X, MD had nonauthorized reconsideration for thoracic X as not medically necessary. Rationale: “Per Official Disability Guidelines by MCG (ODG), Diagnostic X, "Recommended prior to considering X. Not recommended in the X. Criteria for Diagnostic X: Clinical presentation should be consistent with X. X is not recommended for the X. In this case, the patient sustained an

injury to the X. On X, the patient complains of chronic pain that is rated X. The pain is constant and is made worse by sitting and lying down and is made better by standing. Regarding this request, however, X are not supported by the evidence-based guidelines. No exceptional factors were noted. As such, the request is not medically necessary, and the appeal is upheld. Thoroughly reviewed provided records including peer reviews. Unfortunately, there are no large high-quality studies demonstrating clinical efficacy of X. Thus, the requested procedure is not recommended by the cited ODG guidelines. There were no exceptional factors noted in documentation to warrant X beyond guidelines. Thus, the requested procedure is not indicated. 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 peer reviews. Unfortunately, there are no large high-quality studies demonstrating clinical efficacy of X. Thus, the requested procedure is not recommended by the cited ODG guidelines. There were no exceptional factors noted in documentation to warrant X. Thus, the requested procedure is not indicated. 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