True Resolutions Inc.

Notice of Independent Review Decision

Case Number: X Date of Notice: X

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

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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who sustained an injury on X. X got injured in a motor vehicle accident. X was involved in a rollover, as a passenger in a van taking X back in an airport to X hotel. The diagnosis included thoracic spondylosis with radiculopathy. On X, X was evaluated by X, MD for a follow-up of shoulder blade pain. X had been able to do X activities and X was working at the time. X main issue was having trouble at night. X had pain in the mid thoracic region around the shoulder blade area. X denied any shooting pain down the arms. On examination, X ambulated with a non antalgic gait and had no tenderness over the thoracic paraspinal region. On X, X was seen by X, MD for thoracic spine pain. X reported X pain remained the same since the accident. X described the pain as constant and achy and rated 3/10. Previous treatments included physical therapy, home exercise program, and medications. X initiated a X. X worked as a X and continued to work at the time. X had discomfort while X taught to X by X. The physical examination showed discomfort in the midline at X with some minor discomfort in the facet joints at that level as well. Thoracic twisting caused some discomfort. The treatment plan was for X. An MRI of the thoracic spine dated X revealed scattered X bright osseous lesions within the X vertebral bodies, likely interosseous hemangioma; no significant canal or neural foraminal narrowing. Treatment to date included medications, physical therapy, and home exercise program. Per the peer review by X, MD on X, the request for X was non-certified. Rationale: “Per ODG criteria for injections include, "X" In this case, the patient has complaints of thoracic spine pain rated 3/10. However, there is no documentation of failure to NSAIDS or physical therapy. Guideline criteria has not been met. Therefore, the request is not certified.” “The request for X is not certified. Therefore, this associated request is also not certified. “Per the peer review by X, MD on X, the request for X was non-certified. Rationale: “The request for X is not medically necessary. The claimant has X level pain. ODG requires a trial of medications and physical therapy (PT) prior to X. This is not documented. Therefore, the request for X is not

medically necessary. “Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews. Unclear why peer reviews did not agree with request for X given the provider met the criteria cited by peer reviews. Patient had prior physical therapy and medications with continued pain in radicular distribution. Patient also had corresponding imaging findings. Requested procedure is warranted. X is medically necessary and certified

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

Unclear why peer reviews did not agree with request for X given the provider met the criteria cited by peer reviews. Patient had prior physical therapy and medications with continued pain in radicular distribution. Patient also had corresponding imaging findings. Requested procedure is warranted. X is medically necessary and certified

Overturned

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

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☐ 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