True Decisions Inc.

Notice of Independent Review Decision

True Decisions Inc.
An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #615
Mansfield, TX 76063
Phone: (512) 298-4786
Fax: (888) 507-6912
Email: @truedecisionsiro.com

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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 at work on X. X had a history of a X. The diagnoses were lumbar contusion, contusion of right hip, right lumbar radiculopathy, and compression fracture of body of thoracic vertebra.

On X, X was seen by X, MD, for an initial evaluation for thoracolumbar spine and lower back pain. X worked as a X, was seen in consultation with a request from X, DC, for persistent pain in the thoracolumbar spine and lower back since a work-related injury on X when X. Since then, X had been treated nonoperatively with X initially, and more recently, X had completed another X. X could never return to work following the injury. X had an MRI scan of the right hip and lumbar spine and an x-ray of the right hip and lumbar spine, which were done in a X facility on X. X right hip x-ray was done on X, soon after the X. X x-ray was done in X and the MRI done in X had shown a X. These x-rays and an MRI scan were done X months after the original injury. Although the X because the MRI was done X months after the injury, there was no sign of any X. At the time, X symptoms were predominantly back pain which radiated down the right leg all the way to the toes. It followed the X. X also had X. X back pain was about X in intensity and radiated down the right leg. It was associated with tingling, numbness, and weakness in the right X distribution. X had not been able to return to any work. On examination, X blood pressure was 140/102 mmHg. X was in no acute distress; was well developed, well nourished. X came walking without using any walking aids. X was sitting uncomfortably. X was able to get up from the chair and walk with a slow, broad-based gait with a mild antalgic limp in the right leg. X had difficulty in walking on X toes, and the heel tended to drop, indicating an ankle plantar flexion weakness more on the right leg. Movement of the lumbosacral spine was limited, with

hands barely reaching mid-thigh. X had tenderness in the lumbosacral junction. Extension was limited to X degrees. Straight leg raise (SLR) was positive on the right at X degrees for the root tension sign. Neurologically, X had tingling and numbness in the right X. In the cervical spine, X had normal range of motion in both upper extremities and was neurologically intact in both upper extremities with symmetrical reflexes. X had mild tenderness over the right hip joint, and rotation of the right hip joint reproduced mild pain in the lateral aspect of the right hip, possibly from pincer-type impingement syndrome. X came with an MRI of the lumbar spine from X and right hip MRI scan of X and thoracic spine x-rays from X, done in X. The thoracic spine x-ray showed X. The MRI in X did not show any X. X did not have any MRI scan or x-ray of the lumbar spine or thoracic spine soon after the trauma. However, X had x-ray of right hip that was done in X few days after the X. The MRI scan of the lumbar spine also showed X. The other X. X had a history of a X. Since then, X bad been treated nonoperatively initially for X months of X. X had X as described above with X. X also developed X which was most likely resulting from the X. For the X. For lumbosacral spinal pathology with X was recommended.

On X, X underwent procedure of X. The procedure was performed by Dr. X.

X-rays of the thoracic spine dated X revealed a X. There was X. The X were preserved, and the X were intact. The X were unremarkable.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “As per guidelines, "X is not recommended for Cervical spine pain. Lumbar spine pain. Thoracic spine pain." Guidelines are not typically supportive of X. There were no

extenuating circumstances in this patient's clinical data to support otherwise. Therefore, this request is not reasonable and medically necessary at this time. This is based upon this reviewer's clinical experience, the entire clinical picture, standards of care and evidence-based medicine, as well as the cited guidelines and/or literature. Recommend non certification for X."

On X, Dr. X had placed an appeal request for X.

Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The ODG states that X are not recommended as a first-line option due to inconclusive benefit, lack of benefit or potential harm. X are not recommended for thoracic spine pain. Intra-articular access is confirmed using X. The original non-certification of the X. In this case, the claimant has X. The claimant has X. The physical examination shows decreased X. The claimant has X. The provider is recommending a X for symptom relief. However, the guidelines do not recommend X. Additionally, the documentation does not highlight objective deficits of the thoracic spine during the physical examination to support the request for an X. Therefore, the medical necessity of the request cannot be established. The prospective appeal request for X is for non-certification."

Based on the submitted medical records, the requested X is not medically necessary or medically appropriate. X are not supported by the guidelines. In addition, the records do not present and examination which would demonstrate the presence of X. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified

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

Based on the submitted medical records, the requested X is not medically necessary or medically appropriate. X are not supported by the guidelines. In addition, the records do not present and examination which would demonstrate the presence of X. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified

Upheld

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE