

True Decisions Inc.
Notice of Independent Review Decision
True Decisions Inc.
An Independent Review Organization
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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date:

IRO CASE #:

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

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PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who sustained an injury on X. At work, X was sitting in an office chair that had a broken left arm rest. The broken left arm rest had been replaced with a paper towel roll. As X leaned on the paper towel roll, substituting for the left arm rest, it gave way and X slipped and fell to X left. X caught X during the fall and X did not fall all the way from the chair. X reports that X hurt X left shoulder, left arm, and X low back. The diagnosis included sprain of ligaments of thoracic spine, initial encounter.

X was seen by X, DO on X for chronic persistent neck, left shoulder, and arm and hand pain associated with numbness, and weakness and weakness about X left shoulder. X rated X pain X. X felt X pain as getting worse. X also endorsed numbness and tingling into the left hand middle two digits. X admitted to temperature changes and sensitivity to touch. X also mentioned sleep loss, headaches, stiffness in X neck and upper back and X was also having back and leg pain. X admitted to interscapular pain also. Valsalva maneuvers were mildly provoking. X CESD was X. The risk for X. The spot urinalysis was X. X PMP was X. X past medical history was remarkable for X. X reported medications tried X were causing X. On examination, X was in moderate distress. X walked with X. Neck was X. There was marked X. X had decreased X. X had X abduction and an internal and external rotation left shoulder as compared to the unaffected limb. X had marked trigger points in the neck, shoulder, interscapular, and upper back area. The assessment was X. X was instructed to X. X were prescribed. X was encouraged to follow-up with surgeon regarding left shoulder for surgical intervention.

On X, X visited X/ X for left shoulder and lower back pain. X rated X pain X. X was recently seen by X on X. X continued to recommend X and was

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awaiting approval. X did mention that any delay in this treatment would lead to refractory and costly pain complaint. X continued to complain of radiating pain across both shoulders. X had specific tenderness at X. Dr. X did raise X recent oral medications including X. X was taking X at night. X blood pressure was 145/94 mmHg. On examination, X appeared obese. X had a paucity of movement. The passive range of motion of the shoulders was essentially normal but active and was essentially nil. X appeared to make almost no voluntary movement of X upper extremities. There was tenderness at X was noted. X was showing signs of reactive depression and anxiety. The assessment was lower back strain and left shoulder strain. X were refilled. Approval for X was pending with Dr. X.

An MRI of the cervical spine dated X revealed X. An MRI of the left shoulder on X demonstrated X.

Functional capacity evaluation dated X by X, DC documented X could not completely perform in the X to X pound heavy lifting category on an occasional basis. Therefore, X must be listed in the Light- medium lifting category and should be restricted to no more than X pounds of dynamic lifting on an occasional basis and X pounds on a frequent basis. X was unable to complete parts of this test due to increases in acute pain levels and spasms on attempted performance of tests. X was moderately-severely limited functionally. X could not safely perform their job demands based on comparative analysis between their required job demands and their ongoing evaluation outcomes. It was opined that X would benefit from a X to further strengthen and improve functional capabilities as well as improving pain coping mechanisms

Treatment to date included medications (X), X, and X.

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Per the Notice of Adverse Determination by X, MD on X, the request for X was non-certified. Rationale: "Per ODG, "X. Physical therapy, or documentation of patient intolerance to physical therapy. "In this case, pain at the X. X is not a recommended treatment for X. Furthermore, it is unclear why X. The request is not shown to be medically necessary. Therefore, the request for X is non-certified."

Per Physician Advisor Determination review by X, MD on X, the request for X was non-certified. Rationale: "Based on the records reviewed, the patient reported moderate to X. X has radiating pain across both shoulders. X has specific tenderness at the X. On examination, X had tenderness at X with flexion, lifting and bending noted. The MRI showed X. The patient has X. In this case, the patient has X. X are not a recommended treatment for X. Additionally, the patient's physical examination findings did not document gross motor weakness, sensory loss, and myotomal dermatomal findings. Quantifiable measures of objective neurological findings were not present in the medicals provided to full validate the presence of radiculopathy. As such, this request is not supported at this time."

Thoroughly reviewed provided records including imaging findings, provider notes, and peer reviews.

Patient with continued back pain but unclear if this pain is radiating in radicular distribution or in distribution corresponding to imaging findings. Other neurologic features or examination findings of radicular pain are also not present in the documentation provided. Thus, X request is not warranted. X is not medically necessary and non-certified

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

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DECISION:

Thoroughly reviewed provided records including imaging findings, provider notes, and peer reviews.

Patient with continued back pain but unclear if this pain is radiating in radicular distribution or in distribution corresponding to imaging findings. Other neurologic features or examination findings of radicular pain are also not present in the documentation provided. Thus, X request is not warranted. 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