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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 mechanism of injury was not documented. The diagnosis was discogenic cervical and lumbar pain status post L5-S1 fusion as a direct result of a work-related injury on X.

On X, X visited X, MD for a follow-up visit. X was being followed for discogenic cervical and lumbar pain status post L5-S1 fusion as a direct result of a work-related injury on X. X had completed a course of X. X had improved with the X but continued to be symptomatic. X stated the neck pain was a level of X and X low back pain was X. Examination of the upper extremity / spine revealed minimal restriction in flexion, extension, and rotation of the cervical spine. X did not have the tenderness to palpation in the cervical spine. There was moderate restriction in flexion, extension, and rotation of the lumbar spine. X had tenderness to palpation in the lumbar spine. Straight leg raise was X. There was X in the lumbar spine. Review of the imaging results revealed X. The rest of the cervical spine MRI was X. There was X. There was X. There were postoperative changes at X. The fusion appeared solid laterally and the facet joints showed X. The remainder of the lumbar spine MRI was X.

Treatment to date included X.

Per a utilization review notice of adverse determination dated X, the request for X was denied by X, MD. Rationale: "Regarding X. Progress

notes by orthopedic surgery dated X state that there is already usage of X. Accordingly, it is unclear why there is a request for the addition of X. No specific justification is provided. Without additional information, the request for X is non-certified. Non-certification of the requested medication is not intended to imply abrupt discontinuation where there is a risk of adverse effects, including withdrawal symptoms. If medical necessity for ongoing medication use is not supported, a tapering program should be developed to avoid abrupt discontinuation of the medication. Regarding X, the Official Disability Guidelines support the usage of this medication for acute or subacute back pain or neck pain with spasticity. There should be a X. This claimant does not have acute or subacute pain, but rather chronic pain from X. As such, the request for X is non-certified.

Per a Letter of Medical Necessity dated X, Dr. X wrote that X suffered a lumbar and disc herniations as a direct result of a work-related injury on X. X had undergone X. X was only taking X. The pain medication that Dr. X prescribed would help to keep X pain under reasonable control, which X reported pain level of X radiating to the lower extremities and level X in the midcervical region. Dr X did not believe X was a candidate for X. Therefore, Dr. X requested that the X be approved.

Per a utilization review appeal request denial letter dated X, the request for X was denied by X, MD. Rationale: "The ODG supports X. The ODG supports X. In this circumstance, the claimant reports chronic neck and low back pain X. The provider states the claimant is utilizing X on an as-needed basis. They have not been taking X. The provider has recommended X. There is not documentation of acute or subacute neck and low back pain with muscle spasming and no documented failure of anti-inflammatories to support the use of X. Additionally, the use of X is not supported. There is not documentation of X. Additionally, initial use of the X. As such, the appeal request for X are non-certified."

Based on the submitted documentation, the claimant has chronic pain. The guidelines do not support the X. Furthermore, there is no documentation that the patient has X. The use of X. No new information has been provided which would overturn the previous denials. X are not medically necessary and non-certified.

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

Based on the submitted documentation, the claimant has chronic pain. The guidelines do not support the X. Furthermore, there is no documentation that the patient has X. The use of X. No new information has been provided which would overturn the previous denials. X are 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:

- 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