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An Independent Review Organization
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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. X was X. X suffered X. The diagnoses were radiculopathy, lumbar region; chronic pain due to trauma, postlaminectomy syndrome, not elsewhere classified; pain disorder with related psychological factors, opioid dependence, uncomplicated; and encounter for pre-procedural laboratory examination.

On X, X presented to X, MD, for follow-up of X. At the time, X rated the pain X. X reported X. X reported pain scale X most days despite X. X had X. Physical examination revealed X. Sacroiliac joint showed X. Neurological examination showed X. The gait was X. Recent MRI of the lumbar spine showed X. Treatment plan included a X.

An electromyography (EMG) / nerve conduction velocity (NCV) study of the bilateral lower extremities dated X, revealed X. Muscle spasms in the X. Severe left (X) and X was affecting the X. X was affecting the X.

Treatment to date included X.

Per a utilization review adverse determination letter / peer review report dated X, the request for X was denied by X, MD. Rationale for denial of X evaluation: "ODG by MCG, Mental Illness and Stress; Pain Chapter, Online Version, (Updated X), Psychological Testing states, "X." In this case, the claimant has complaints of lumbar spine pain. Physical exam revealed X. The claimant was diagnosed with radiculopathy, lumbar region; chronic pain due to trauma; postlaminectomy syndrome; and pain disorder. The claimant has been treated with X. Treatment plan includes a X. The medical necessity has not been established as the medical documentation X. However, a X is not shown to be medically necessary at this time for reasons in addition to the X. There are no extenuating circumstances to

warrant deviation from the guideline variance. As such, the request is noncertified.” Rationale for denial of X: “ODG by MCG, Low Back; Pain Chapter, Online Version, (Updated X), X states, "X" In this case, the claimant has complaints of lumbar spine pain. Physical exam revealed X. The claimant was diagnosed with radiculopathy, lumbar region; chronic pain due to trauma; postlaminectomy syndrome; and pain disorder. The claimant has been treated with X. Treatment plan includes a X. The medical necessity has not been established as the medical documentation X. Additionally, there is no evidence of a X. There are no extenuating circumstances to warrant deviation from the guideline variance.

Therefore, the request is noncertified.” Rationale for denial of X: “ODG by MCG, Pain Chapter, Online Version, (Updated X), Office Visits for Pain states, "Recommended based on medical necessity for individual patients. Evaluation and management (E&M) outpatient visits to doctor's medical offices play a crucial role in proper diagnosis and return to function for injured workers and should generally be encouraged. Specific need for clinical office visits with a healthcare provider must always be individualized based upon review of patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment." In this case, the claimant has complaints of lumbar spine pain. Physical exam revealed X. The claimant was diagnosed with radiculopathy, lumbar region; chronic pain due to trauma; postlaminectomy syndrome; and pain disorder. The claimant has been treated with X. Treatment plan includes a X. The medical necessity has not been established as the medical documentation X. Additionally, there is no evidence of a X. The pain management specialist to discuss X appears to be premature and there are no extenuating circumstances to warrant deviation from the guideline variance. Therefore, the request is noncertified.”

Per a reconsideration review adverse determination letter dated X, and a peer clinical review report dated X, appeal request for X was denied by X, MD. Rationale for denial of X: “Prior report dated X, by X, MD, indicated the request for X was non-certified noting the medical necessity has not been established as the medical documentation X. However, a X is not shown to be medically necessary at this time for reasons in addition to the lack of X. There are no extenuating circumstances to warrant deviation from the guideline variance. ODG by MCG states that X may be indicated when all of the following are present X is needed, as indicated by the presence of all of the following: X. In this case, the

claimant reports chronic mostly axial low back pain rated at X. Physical examination noted X. X noted. There is X. The claimant is not an appropriate candidate for X at this time and therefore X is not indicated. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. As such, the request is recommended non-certified.” Rationale for denial of X: “Prior report dated X, by X, MD, indicated the request for X was non-certified noting the medical necessity has not been established as the medical documentation X. Additionally, there is no evidence of a X. There are no extenuating circumstances to warrant deviation from the guideline variance. ODG by MCG do not recommend X in rare cases. X may be considered as described for favorable X, including all of the following: X. In this case, the claimant reports chronic mostly axial low back pain rated at X. Physical examination noted X. X noted. There is X. The submitted clinical records X. The claimant has X. Guidelines require X. There is X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. As such, the request is recommended noncertified.” Rationale for denial of X: “Prior report dated X, by X, MD, indicated the request for X was non-certified noting the medical necessity has not been established as the medical documentation X. Additionally, there is no evidence of a X. The pain management specialist to discuss X appears to be premature and there are no extenuating circumstances to warrant deviation from the guideline variance. ODG by MCG recommends office visit based on medically necessity for individual patients. In this case, the claimant reports chronic mostly axial low back pain rated at X. Physical examination noted X. X noted. There is X. The submitted clinical records X. The claimant has X. Guidelines require X. There is X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. As such, the request is recommended non-certified.”

The requested X is not medically necessary. The medical records X. There is X. The previous denials were in line with the guidelines. No new information has been provided which would overturn the previous denials. Thus, medical necessity cannot be established. 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:

The requested X is not medically necessary. The medical records do not document that a X. There is X. The previous denials were in line with the

guidelines. No new information has been provided which would overturn the previous denials. Thus, medical necessity cannot be established. 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