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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured at work on X. Per the determination note, X reported "patient" fall on X. The diagnosis was lumbar radiculopathy.

On X, X was evaluated by X, FNP / X, MD for a follow-up of low back pain. The lower back pain was radiating to bilateral feet, left greater than right, with numbness / tingling. It was dull in nature. X had X on X which provided X with X relief for X months. X rated X pain X with average pain level X. On examination, weight was 243 pounds and body mass index (BMI) was 34.86 kg/m2. Musculoskeletal examination showed X. X was noted. Slump sit examination was X. Reflexes were X. The strength at left hip flexor was X; bilateral knee extension/ flexion, ankle dorsiflexion / plantar flexion was X. Sensory examination showed light touch diminished to bilateral X.

Treatment plan was X. An MRI of lumbar spine dated X revealed X. No X was present. There was X. The disc was significantly X. No X was present. Treatment to date included X. Per the adverse determination letter dated X by X, MD, the request for lumbar "X was denied. Rationale: "The Official Disability Guidelines supports X if there are complaints of X. There should be corresponding objective findings on physical examination and MRI. X are supported if there is at least X. Progress notes dated X include complaints of lower back pain radiating to the bilateral feet with numbness and tingling. However, physical examination on this date only reveals a X. Lower extremity strength was

normal, and reflexes and sensation were not assessed. Additionally, MRI of the lumbar spine does not reveal X. Absent these objective findings, this request
for X is non-certified."

Per the notice of adverse appeal determination letter dated X by X, MD, the request for X was denied. Rationale: "The Official Disability Guidelines state that X. Based on the submitted clinical records, the request for X does not meet the guideline criteria. While the claimant reports low back pain radiating to both feet with numbness and tingling, physical examination findings are limited to a X, with normal lower extremity strength, and reflexes and sensation not assessed. Per guideline criteria, objective X. The MRI of the lumbar spine (X) does not indicate X. The request includes X, which is not a recognized indication Under Official Disability Guidelines (ODG) criteria. The guidelines do not support the routine use of X, and no exceptional medical necessity has been demonstrated in the clinical documentation to justify its use. Therefore, the request for X is non-certified.

Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews. The patient may have pain in potentially X. This pain correlates with X. The patient had X. Given such, the request for X is warranted. However, without specific documentation of X is necessary. X is medically necessary and certified and under
X is not medically necessary and non-certified

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

Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews. The patient may have pain in X. This

pain correlates with X. The patient had X. Given such, the request for X is warranted. However, without specific documentation of significant X is necessary. X is medically necessary and certified and under
X is not medically necessary and non-certified

Partially Overturned

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