

True Resolutions Inc.
Notice of Independent Review Decision

True Resolutions Inc.
An Independent Review Organization
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PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X when X. X was diagnosed with a X. A functional capacity evaluation was conducted on X. There were X found in the study. There was X. X demonstrated X demand level versus X demand level as required by X job. X, MD evaluated X on X for continued moderate X. It was noted that X. Examination of the X showed X. There was X. The X. It was noted that as per FCE, X would benefit from continuation of X. A medical document dated X indicated that subjectively, the symptoms of pain were described as X in the affected body region. There was documentation of a X. Objectively, there was documentation of X. There was documentation of what was described as X. Treatment was provided in the form of a X. The diagnosis was X. Objectively, there was an X. Treatment to date included X. An Adverse Determination Letter dated X indicated the request for X was non-authorized. Rationale: "Attempts at conducting a PEER to PEER review were not successful. For the described medical situation, Official Disability Guidelines would not support a medical necessity for this specific request as submitted. As documented in the summary, there has been a previous attempt at treatment in the form of X. The requested amount of treatment in the form of X would exceed what would be supported per criteria set forth by the above-noted reference for the described medical situation. Consequently, presently, medical necessity for this specific request as submitted is not established. As documented above, attempts at conducting a PEER to PEER review were not successful." On X, the request for X was non-certified. Rationale: "For the described medical situation, official disability guidelines would not support a medical necessity for this specific request as submitted. As documented in the summary, there has been a previous attempt at treatment in the form of X. The requested amount of

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treatment in the form of X would exceed what would be supported per criteria set forth by the above-noted reference for the described medical situation. Consequently, presently, medical necessity for this specific request as submitted is not established. As documented above, attempts at conducting a PEER to PEER review were not successful."

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

The ODG recommends up to X. The provided documentation indicates the injured worker X. The injured worker has X. Based on the provided documentation and ODG recommendation, the request for X is not medically necessary, but X are medically necessary.

Recommendation is for partial overturning the two prior denials with certification of X.

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

- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES