True Resolutions Inc.

Notice of Independent Review Decision

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

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:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is X with date of injury X. X stated X. X presented to X, on X for X. X had been X. X continued to X. X had X. X impairment included X. Functional limitations included X. On X, X was evaluated by X, for chief complaint of X. X was X. X stated X. X continued with X. X reported X. X stated the pain was X. X was X. X examination revealed X. X to the X with X. X was X; however, X stated X. X was X. X revealed X. Treatment to date consisted of X. Per a utilization review / adverse determination notice dated X, X noncertified the request for X. Rationale: X. The diagnoses included X. This claimant has had X. X note X states claimant has complaints of X. There are no MD notes provided for my review. Will need updated MD notes along with X notes with detailed, objective, and comparative physical examination findings, and documentation of claimant's objective response to X, to adequately review and support the request for X. Additionally, given the diagnosis, request for X ODG recommendations. Therefore, the proposed treatment consisting of X is not medically necessary. ”On X, Dr. X wrote a letter and documented that X had been under his care since X. X had been X. X had been X. X treatment course was X. X also had X. X had responded to initial treatment and required X. X had X and had been X. X could result in X. Dr. X requested to reconsider approval for X. Per a utilization review / adverse determination notice dated X, X noncertified the request for X. Rationale: “On X, this claimant presented to Dr. X with X. The exam of the X was X. This claimant has been previously approved with X. The request for X exceeds guideline recommendations. Therefore, the proposed treatment consisting of X is not medically necessary.”

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

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review / adverse determination notice dated X, X, MD noncertified the request for X. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that the patient has been authorized for X. The request for X would exceed guideline recommendations. When X exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of X documented. The patient has X and should X with X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

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

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL