True Resolutions Inc.
An Independent Review Organization
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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:

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X who was X. X from X. The diagnosis was X and X. On X was evaluated by X, MD for X. X stated the X, and X. The pain was X. On examination, X was X. There was X. X was X. X was X. Examination on X showed X. There was X. Per Dr. X was X. Our initial attempt to submit for X was denied due to X and Dr. X own that were X. An X was ordered for X. Treatment to date consisted of X. An X of the X. The impression was: X. X suggesting X. Accompanying X. X into the X. Clinical X was recommended X. Per an Adverse Determination Letter dated X the request for X was denied. Rationale: "There is X. Per an Adverse Determination Letter dated X as not medically necessary. Rationale: "Per ODG guidelines, X are recommended as a X. This treatment should be X. In this case, the X. Current X. The patient has X. X showed X. X into X. A successful peer-to-peer call with X, MD was made at X. The details of the request were discussed. Dr. X states to have X. The requested X is not medically necessary and the previous denial is upheld."

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. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no significant X. Early X. There are X submitted for review. There is a X on the most recent office visit note provided. There is no documentation of any X for this X.
Therefore, medical necessity is not established in accordance with current evidence-based guidelines

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