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:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X with date of injury X. X was X. X was X. When X. X continued to X. A X. X reported X. On X, evaluated X for X. X of X. X revealed X. X reported X. X presented X. X and X. Per a X note X, MS, X had a X, MDP on X. On the most recent visit, it was noted that X. The clinical X. X recommended was to X. During this treatment X. On the most recent visit, it was noted that X reported X. The clinical impression was X. X recommended was to X. X also had X, MD on X. It was noted that X. The clinical X. X recommended was X. At the time, Dr. X was recommending X. On the X. This X from X. X reported the X. On the X. This X from X. X reported X. On the X. This X from X. X reported X. X noted X. X had X. X helped X. On the most recent X. This X from X. X reported X. X reported X. On the X. This X from X. X reported X. On the most X, indicating X. This X. X reported X. The X was reported as X. On the X. These X. On the most recent X. This X. X on the X. On the X. This X. X of X. X was X, but was X. X had X. X reported X. X with X. Review of X had also been X. Treatment to date X. Per a utilization review dated X, MD denied the requested X. Rationale: “ODG-

TWC supports X. The X so X. In this case, the claimant was X. Review of claim notes that on X, the claimant was X. The provider noted a X. The X has X. On patient X. The X. The X, the claimant has a X. This X. The X is the X. The X has X. Over the X. The claimant reports X. The claimant has X. There is X. After X, it is X. The medical necessity of the request is not X." Per a utilization review dated X, MD non-certified the request for X. Rationale: "X if X. The provider should X. In this case, the X. It also noted that X. It was documented on X that the claimant X. The X. The X has X. Per X, the provider X by ODG, however, the provider notes that the claimant X. The claimant reports X. The claimant X. The claimant is also X. The providers notes that the claimant is X. This X is X. The claimant would like to X. The provider is requesting X. However, the claimant has X. There are X the recommendation of guidelines would provide a X. It was also documented that the claimant has X. After X to date, it is X. The medical necessity of the request is not evident. Recommendations is to uphold the prior non-certification of the requested X.

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 X to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that the patient X. Current evidence-based guidelines would support X. The submitted clinical X to document X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

True Resolutions Inc.

Notice of Independent Review Decision

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