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 who X. X was X. X and was X. X was on X. The diagnoses were X. X was evaluated by X, DPM on X for follow-up of X. The X and recommended X had been denied. X requested a X to X, as it had X. X reported X. On examination, X was X. X on the X. There was X on the, X. On the X, there was X. X on the X. The X and X. X and X and X. X showed X. X showed X. An MRI of the X on X revealed X. X was X. X and X. There was X with X. Associated X was X. X and X. X-rays of the X. X were X. Treatment to date included X. Per a utilization review adverse determination letter dated X, MD documented that the request for X was noncertified. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, this request is non-certified. As the medical necessity of the requested X was not established the X. Per a reconsideration review adverse determination letter dated X DPM upheld the previous denial. Rationale: "Based on the Notification of Adverse Determination by X, MD dated X, there was a prior determination whereby the request for X was

non-certified. The reviewer noted that there was a X. Moreover, the guideline indicated that the patient should have X. Thus, the request is not supported. As the requested X is not X are also not needed. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified."

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 recommended as medically necessary, and the previous denials are overturned.

The requested X was overturned and medically necessary, therefore the request for X is also medically necessary and overturned.

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