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 injured on X. X stated that X. X also sustained X. Since that time, X had X. The diagnosis was X. X, MD saw X in follow-up on X. X complained of X. MRI of the X had been denied. X was able to X. X was able to X. The pain was X. Pain level at the X. The pain was X. X made the X. On review of X. On examination, X. X was noted in the X. X on the X. Per an office visit note dated X, an MRI of the X. There were also X. Treatment to date included X. Per a Utilization Review Adverse Determination Letter dated X, by X, MD, the request for MRI of the X was noncertified with the following rationale: "This is a X. Patient's X is from X. All we are told is that the patient has X. No examination is documented. X is provided. Therefore, the request for X, is not medically necessary." Per a Reconsideration Review Adverse Determination Letter dated X, by X, MD, the prior denial was upheld, with the following rationale: "Based on the clinical information provided, the X Request for X is not recommended as medically necessary. The initial request was non-certified noting that this is a X. Patient's X is from X. All we are

told is that the patient has X. No exam is documented. No indication for X is provided. Therefore, the request for X, is not medically necessary. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The most recent X findings documented are from X. Serial office visit notes since that time note X. There is no clear rationale provided to support an MRI at this time, given X in the X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines."

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

Given the current clinical data, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a Utilization Review Adverse Determination Letter dated X, MD, the request for MRI of the X was noncertified with the following rationale: "This is a X case. Patient's original injury is from X. All we are told is that the patient has X. No examination is documented. X a new MRI of the X is provided. Therefore, the request for X is not medically necessary." Per a Reconsideration Review Adverse Determination Letter dated X, by X, MD, the prior denial was upheld, with the following rationale: "Based on the clinical information provided, the X Request for X is not recommended as medically necessary. The initial request was non-certified noting that this is a X. Patient's original injury is from X. All we are told is that the patient has X. No exam is documented. No indication for X is provided. Therefore, the request for X, is not medically necessary. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The most recent physical examination findings documented are from X. Serial office visit notes since that time note X. There is X provided to support an X at this time, given X. Therefore, X is not established in accordance with current evidence-based guidelines." Recommend upholding the previous non-certifications. X reports document no significant changes in X. There are X submitted for review. It is unclear how MRI findings would change the current treatment plan. It is unclear if the patient has X.

Therefore, the request is not medically necessary and upheld.

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