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

Notice of Independent Review Decision

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured X. X had X. The diagnosis was X. X was seen by X, MD on X for X and X. X stated X was X. Since then, X reported X to X that X to the X. X had tried X and X in X with X. Due to the X, X had X and X. X was X. The X was described as X. It was X by X. X was X by X. Examination findings showed X and X. There were X with X. The assessment included X of X. X and X was continued. X (X) was recommended. Due to continued symptoms, X approval was requested for the X followed by the X. Treatment to date included X. Per a utilization review adverse determination letter and a peer review dated X, by X, MD, the request for X was denied as not medically necessary. Rationale: “The request for X is not

recommended as medically necessary. The submitted clinical records indicate that the patient underwent X on X, X and X. There are X office visit notes submitted for review with documentation of the patient's X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines." Per a utilization review adverse determination letter and a peer review dated X by X, MD, the request for X was non certified. The rationale given was as follows, "It is unclear why there is a request for a X for this X. Although there are complaints of X and X on X, progress notes dated X state there is already X with X. The Official Disability Guidelines does not support X such as X if there is X with X. Considering this benefit with existing treatment, this request for a X is not medically necessary."

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

The ODG support X for the treatment of X when there is X that interferes with X and a X. The documentation provided indicates that the worker reports X. The worker reported a X and that X provide X. Current X includes X and X. Previous treatment included a X and X in X with X. Additional treatment has included X. The worker reports X that X. An exam documented X. There is a diagnosis of X. There is a request for X. Given the X and previous X, X would be supported. While there is evidence of X with X, the X is currently utilizing an X, and the use of X to X and X is recommended.

As such, X is supported as medically necessary.

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