

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X with date of injury X. X was X. The X. X, MD evaluated X on X and X. On X presented for a X. X had X. X also X. X was X. Also it was Dr. X. By Dr. X showed X. On X. This was X. This was X. X had a X. X with X and X. X was noted at the X. X did X. This was X. X revealed X. X, but X was noted. X was noted with X. The X. Also X were noted in the X. On X presented for X. X with X. X had X. X also X. X had been X. X was X. As X also it was Dr. X the reviewer may have X. By X. While documented in the X. This was X. This was X. X had a X and a X. X and X. A X was also noted. Again, the X. X was X noted. X but X. X with X and X. X was X. An X. An X there was X. The X in the X. The X at the X were X. These X. Treatment to date consisted of X. X "As the request for X is non-certified, this request is non-certified." Guidelines used was Official Disability Guidelines (ODG) Treatment

Guidelines X. It was also stated that X. The X had noted that this was a X. The X had reported that a X. The X had X. The X had noted that it X. The X noted that there was a X and a X. Per a Peer Review dated X, the appeal request for X was non-certified by X, MD. X. As such, the X request X. Therefore, X recommendation is to X. It was also documented that X, Not recommended, since X.

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

The medical records provided note the X is X. As such, the request for X is not medically necessary. In addition, ODG does not support the X.

The previous denial is upheld as medical necessity is not established.

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