True Resolutions Inc.
An Independent Review Organization
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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

[SUMMARY]:
X with a date of injury of X. X sustained a X. X was X. X was diagnosed with X. X was seen by X, MD / X, MD on X for a X follow-up regarding a X and X. X stated that X request for X was denied. Overall, X was better on X. X reported X with X and X. X continued to report X. X had X and X. X continued to have X. Examination revealed X and X, X, X, and X. Treatment to date included X, X, X, X, and X, X, and X. Per a utilization review decision letter dated X, the request for X between X and X was denied by X, DO. Rationale: "Regarding X, the ODG does not recommend X. X is defined as at least X, at X with or without Proceeding with X does not appear to be X. The claimant reports X with use of X, however, the cited guidelines do not recommend this as a X. There is no documentation reporting X for the treatment of X. This request was previously non-certified in reviews X and

X for the same reason. Based upon this, the prospective request for X is non-certified." Per an adverse determination letter dated X, X between X and X was denied by X, DO. Rationale: "The ODG do not recommend X, if there is a confirmed diagnosis of X, and X for X, this X may be X. There should be documentation of at least X. X is one of X. X are not indicated at this time. It appears that this X has been effective for the claimant and it is not X used for X. However, there was no documentation of X. A request for this X was non-certified in review X. Based on this X, the prospective request for X is non-certified." Per a Utilization Review decision letter dated X, the request for X between X and X was denied by X, MD. Rationale: "The Official Disability Guidelines do not recommend X, X, as X. It is recommended as a X after X with X if there is a confirmed diagnosis of X. There should be documentation of at least X use with a X. X is X. The claimant reports X however, the cited guidelines do not recommend this as a X. There is no documentation reporting X. This request was previously non-certified in reviews X, X, X, and X for the same reason. Based upon this, the request for X is non-certified.

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

X is a X for the X. After reviewing the clinical records, medical necessity is established. Per X: "X as a X for X resulted in a X than X." "In this X, X randomly assigned patients with X. "The percentage of patients with a X."Per X: "X reduces the need for X use in patients with X." "In this X, X." "X reduces the need for X and X use in patients with X." The patient has X multiple other X. There is a valid scientific and medical basis for the requested treatment and evidence that the requested service is X for this individual under these circumstances. X is medically necessary for this patient's condition.

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