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

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who sustained an injury on X. X reported X was X when X. The diagnoses included X. X was seen by X, MD on X for a follow-up of X. It was present for X and was X. It was described as X. It was X. It was associated with X. X was doing X and stated there X. On X examination, the X revealed X. X was X. X was X. X examination demonstrated X in the X except for X. On X, X was evaluated by X, MD for X. The X was X. X were X. The amount of X was X.X-rays of the X on X showed X. An X of the X on X was consistent with X and revealed X. An undated MRI of the X showed X. An undated MRI of X was X. Treatment to date X. Per Physician Advisor Determination by X, MD on X, the request for X was non-certified. Rationale: “Per ODG, "X." There are no documented extenuating circumstances to support an exception to the guidelines regarding X. The request

is not shown to be medically necessary. Therefore, the request for X is non-certified." Per Physician Advisor Determination by X, MD on X, the request for X was non-certified. Rationale: "Regarding X."

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 not recommended as medically necessary, and the previous denials are upheld. Per Physician Advisor Determination by X, MD on X, the request for X was non-certified. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that X is not recommended. X is not recommended X. X of the X notes no evidence of X.

Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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