

# 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 with a date of injury X. X was X when X. X was diagnosed with X. On X, X was seen by X, DC for X. The symptoms were located X. They were described as X. X stated that X since X work-related injury. X noted X while X. X ongoing symptoms X. Examination of the X revealed X and X. X was noted over the X. There was X over the X. X had X. X was noted. X test and X test were X. X test was X as the X. X was X. Treatment to date included X. Per an initial Adverse Determination letter dated X, the request for X was denied by X, DC. Rationale: "Recommended as an option for X and X, X and X (very low-quality evidence, but may be a conservative option). Although the record state the patient is in need of X, there is no indication of X and no documentation of X. Therefore, this request is not medically necessary". X, DC wrote an appeal letter on an unknown date documenting that X was under X care from X. X had undergone X. X was advised

to X, which was helpful to X. X was recently evaluated on X and X was X, so X requested a X. Dr. X recommended a X so that X symptoms continue to X. Per a Utilization Review Decision letter dated X, the prior denial was held by X, DC. Rationale: "Based on the medical records that have been submitted for review, and after talking with Dr. X, X explained that the claimant's current X was X. Dr. X continued to explain that the X helps X, and when X then it helps X. According to the ODG, X are not recommended for prevention, but they are recommended for specific treatment of X (very low evidence, but may be a conservative option). X has been treated with X and X, based on the medical records and after talking with Dr. X, the claimant does not present with any X; therefore, X recommending non-certifying this request for 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. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records fail to provide documentation of X or X. Guidelines note that X is not recommended for X and there is very low evidence to support use for treatment of X. When treatment is outside the guidelines, exceptional factors should be noted. There are no exceptional factors of X documented. 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