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 on X. X had a X resulting in X after X. The diagnosis was X. On X, X was seen at X by X. X reported X and stated X was X. The assessment was X performed X with X. X was X but X was X to X. X was measured at X. X stated X would benefit from X. X was educated on X, X. X was X. On X, X was seen at X by X. X reported X was X from doing X but was ready for X. The assessment was despite complaints of X, X was able to X and verbalized X as X. X potential was X. X was evaluated by X on X for follow up of X. The X was X. X had next appointment with X on X. X had X. X had X. X stated X had X since the last visit. On examination, X was X. The assessment was X. X was recommended to continue X. Review of X performed on X revealed X. An X of the X revealed X and X. There was no evidence of X. X was noted. There was X. There was X noted. Treatment to date

included X. Per a utilization review adverse determination letter dated X by X, the request for X was denied. Rationale: “The claimant presented with continued complaints of X and X. Physical exam revealed X. However, the claimant is noted to have had X to date, in excess of guideline recommendations, and should be well versed in X by this time. There appears to be no reason that the claimant could not continue with X. Therefore, medical necessity has not been established.” Per a reconsideration review adverse determination letter dated X, the request for X was denied. Rationale “Per the ODG by MCG X is recommended for X. The claimant reported X. The claimant demonstrated X with X to include X. On physical examination there was X. There was X to the X. The claimant was X. However, the request exceeds guideline recommendations for the X requested as the claimant has X with no documentation of functional deficits preventing the claimant from transitioning to X. As such, the request for X is not medically necessary.”

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

The ODG supports X following X. The documentation provided indicates that the X underwent X. The X has X following X. The most recent evaluation is on X which documents X. The X was noted to be X. There is a current request for it X. When noting the guidelines have been exceeded, there is no recent evaluation indicating ongoing improvement with X and persistent X, and no indication X cannot be utilized, additional X would not be supported.

As such, X is not 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