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 injured X on X while X. The diagnosis was X. X was seen by X, MD on X. X had been taking X and had X of the X on X. X completed about X with some X. X reported that X saw Dr. X (X) and was requested X, which X denied so they were appealing the decision. X reported that the X was helping X with the X. X was also given X to help X. X rated the X a X (X) and described as X. X also reported X referral X the X with X in X. X had a X (X) on X. X had helped to some extent. On examination, X was X with X, X and X was X with X. X was X for X. X was unable to perform X greater difficulty on the X. There was X on the X, X and X. X on the X was X on X. The assessment was X. X was recommended to continue with Dr. X recommendation for X. X was completed. X was allowed to X. On X, X was evaluated by X, DO for follow up. X continued with X. Apparently, X went to a

designated doctor who X while examining X, that was not uncommon. X was still X with X. X still had X at X and X more on the X than the X. Dr. X stated as a result, they were going to recommend X. Dr. X stated unfortunately, the peer doctor apparently did not review their notes or dictations and apparently X was not familiar with X. X initiates care after X, X, X, which this gentleman all had did not succeed with X. They were not talking about X or X. Furthermore, it was standard of care in the local, national and world communities as X had practiced this specialty for X to provide X in the X. This was not X. This was X to provide X in which X can appropriately address the X. With patients X, Dr. X stated X could only imagine, they were X and X the X which would prevent the X from even getting into the X. That was why it had become a standard of care treatment. That was not to be discussed as they would not perform a procedure, which was not the community standard, which would be perceived as malpractice. X furthermore stated X did not want to X noting that there would be X, due to X and X, and a X to be placed into the X. X to obtain to X would also require X and not X. As a result, they were going to resubmit for X. Dr. X suggested a physician familiar with this procedure and the community standard review this case. That being said, X was thankful that the X for X as well as the X were X. That was including X and X, which was helping X with the X and X of X and X. X understood, X had to stop X to X. Dr. X stated they would schedule X for that as soon as possible. The interest of the patient first and foremost as well as the insurer to see this case moves forward and resolution obtained and we would arrange for it as soon as possible. Dr. X stated any further delays would lead to X and X with further X anticipated. X showed X as X answered X on X, X was noted. An X of the X dated X revealed X. There was X. There were X and X of the X. X dated X was X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “As noted in ODG's X, X are not recommended due to a lack of X. The attending provider failed to furnish a clear or compelling rationale in favor of the decision to pursue X in the X of the unfavorable ODG position on the same. Therefore, the request is not medically necessary.” Per a reconsideration review dated X by X, MD, X and X was denied. Rationale “Evidence-based guidelines do not support X to the X. No exceptional factors are noted. Hence, this request is not medically necessary, Thus, 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 medical records and request were reviewed. The treating provider is requesting authorization for X. The treating provider has noted X. X diagnosed X. The claimant reports X with X and X consistent with X. Given the documentation available, the request of X is considered 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