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 was injured on X. X was evidently involved in X. The diagnosis was X. On X, X was evaluated by X, DO for X. The initial date of injury was X. X was evidently involved in X. X proceeded with X and X. X dated X revealed at X. The case was reviewed by Dr. X, X. X had X. There was X in which there was no X symptoms. On examination, the X was X and X and X with X. The X was X. Examination of the X demonstrated X over the X and X and X in X. X and X were X. The assessment was X. X was recommended X and X. An X dated X revealed evidence for X. There was no 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: “Per evidence-based guidelines, a X Is the preferred procedure

to determine X and it is conditionally recommended prior to considering X. No more than one set of X should be performed prior to X. In this case, the patient had been certified with a similar procedure on X. This had been clarified to be a X, and X received the X on X. There is no support in repeating this X at the same X. Guidelines recommend no more than X prior to X. The request is not medically necessary." Per a reconsideration review letter dated X, DO, the request for X was denied. Rationale" The Initial request was non-certified noting that, "Per evidence-based guidelines, X Is the preferred procedure to determine X and It Is conditionally recommended prior to considering X. No more than X should be performed prior to X. In this case, the patient had been certified with a similar procedure on X. This had been clarified to be a X procedure, and X received the X on X. There is no support in X at the same X. Guidelines recommend no more than X prior to X. The request Is not medically necessary." There Is insufficient information to support a change in determination, and the previous non-certification is upheld. Current evidence based guidelines only support X. The submitted clinical records Indicate that the patient has previously undergone X. Therefore, medical necessity is not established in accordance with current evidence based guidelines."

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 patient X on X. The patient's response to this procedure is not documented. Current evidence based guidelines would only support X. Additionally, the patient is noted to present with a diagnosis of X which is a relative contraindication to the requested procedure.

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