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An Independent Review Organization
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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

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:

- Overturned Disagree
- Partially Overturned Agree in part/Disagree in part
- Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X and hurt the lower back. The assessment was X.

On X, X was seen by X, MD for X. X had X previously by Dr. X. X reported that the X had worked well for X and was on the left side. X had never had an infection. X denied any history of X. On examination, X was alert and X mood was X.

Strength was noted to be X in hip flexors, knee extensors, ankle dorsiflexion and plantar flexion, and extensor hallucis longus. X body mass index (BMI) was 28.86 kg/m². X would like to proceed with X.

The treatment to date consisted of X.

Per a utilization review adverse determination letter dated X, the request for X as requested by Dr. X with X was denied by X, MD. Rationale: "Per ODG by MCG Last review / update date: X X. The patient has had a work-related injury in X and subsequently has had X. The patient has subsequently had X by Dr. X, Neurosurgeon. The patient has not had a recent psychological evaluation to indicate whether continued use of the X. Also, the ongoing symptoms of X, are not documented on the recent clinical office visit. A recent X performed on the patient are also not documented (Medical Report Visit / Note X, X, MD, Neurosurgeon). Therefore, the requested X estimated dates of service (DOS) X is denied."

Per a letter dated X, X, MD documented that X presented to X. X had X previously by Dr. X. X reported that the X had worked well for X. X would like to proceed with X. This would be X and it was necessary and required for continuity of care. Despite this and the recommendations of X collaborating physicians and healthcare team; the request was declined and not approved by X Worker's

Compensation insurance. They again had recommended that they proceed with X. They were requesting to reconsider the request as it had a significant impact on X quality of life and activities of daily living as X had been successfully maintained on this course of X.

Per a reconsideration review adverse determination letter dated X, the appeal request for X as requested by Dr. X with X was non-certified by X, MD. Rationale: The Official Disability Guidelines recommend X. In this case, the patient was seen for X. The patient is status X. The treating provider recommends X. However, the records did not show subjective and objective findings to support the medical necessity of the request. In addition, a recent psychological evaluation was not provided.”

In review of the clinical findings, the claimant has used a X. The claimant endorsed X. The claimant had X. The current X. Therefore, X is reasonable and within standard of care. As such, it is this reviewer’s opinion that medical necessity is established for the service in dispute: X as requested by Dr. X with X; and the previous denials are overturned. X as requested by Dr. X with X is medically necessary and certified

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

In review of the clinical findings, the claimant has used a X. The claimant endorsed X. The claimant had X. The current X. Therefore, X is reasonable and within standard of care. As such, it is this reviewer’s opinion that medical necessity is established for the service in dispute: X as requested by Dr. X with X; and the previous denials are overturned. X as requested by Dr. X with X is medically necessary and certified

Overtured

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE