

**True Decisions Inc.**

***Notice of Independent Review Decision***

**True Decisions Inc.**

**An Independent Review Organization**

**1301 E. Debbie Ln. Ste. 102 #615**

**Mansfield, TX 76063**

**Phone: (512) 298-4786**

**Fax: (888) 507-6912**

**Email: [manager@truedecisionsiro.com](mailto:manager@truedecisionsiro.com)**

**PATIENT CLINICAL HISTORY [SUMMARY]:** X who was injured on X following a X. The diagnosis was X. On X, X was evaluated by X, MD for complaints of X pain. The pain X. The pain had been going on for X. The pain was described as X. The pain was made worse by X. As verbalized, X was working full duty. X was able to X. The pain level at the time of the visit was X, at worst was X, and at best was X. The pain felt like X. X also had X. Review of systems was positive for X due to pain. On examination, X was X. X was in no X. X examination revealed good X. Deep X were diminished in the X. X was negative X. X pain was noted on X. X had pain in the X. The treatment plan included X. If the X were successful, X followed by X would be requested. According to the office visit dated X, X complained of X pain. On examination, there were no significant changes in the physical examination since the previous office visit. X would have a follow up in X month for re-evaluation. An office visit with Dr. X on X was documented. X complained of X pain. X was able to X. X was able to X. The pain was rated X. On examination, no significant changes were noted since the prior visit. The plan again was to schedule X for the procedure. The computerized tomography of the X dated X documented X. Prior treatment included X. The X helped but did not relieve the pain completely. A clinical peer review report was completed by X, MD on X. X gave the following opinions: There was a previous adverse determination dated X, whereby the previous reviewer non-certified the request for X. The reviewer noted that the most recent clinical encounter, X, indicated that the patient was experiencing X pain. Body diagram completed indicated X. Physical examination demonstrated X. The computed tomography scan of the X performed X demonstrated X throughout the X. Prior treatments included without benefit, X. The ODG supported the utilization of X for diagnostic purposes in potential X. In this case,

## True Decisions Inc.

### *Notice of Independent Review Decision*

the clinical information submitted was insufficient to demonstrate the failure of X. Therefore, the requested X was not medically necessary. On X, the appeal request for X was non-certified.

#### **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. A clinical peer review report was completed by X, MD on X. X gave the following opinions: There was a previous adverse determination dated X, whereby the previous reviewer non-certified the request for X. The reviewer noted that the most recent clinical encounter, X, indicated that the patient was experiencing X pain. Body diagram completed indicated X. Physical examination demonstrated X. The computed tomography scan of the X performed X demonstrated X. Prior treatments included X. The ODG supported the utilization of X for diagnostic purposes in potential X for pain that was X. In this case, the clinical information submitted was insufficient to demonstrate the X. Therefore, the requested X was not medically necessary. On X, the appeal request for X was non-certified. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. Office visit note dated X indicates that the patient reported X pain relief following X. However, the Official Disability Guidelines require documentation of X. The submitted clinical records fail to establish that this patient has exhausted X. There are no X records submitted for review. Additionally, there is no evidence of a formal plan of additional evidence-based X in addition to X as required by the Official Disability Guidelines. Given the documentation available, the requested service(s) is considered not medically necessary.

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

- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

**True Decisions Inc.**

***Notice of Independent Review Decision***

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES