True Decisions Inc.
An Independent Review Organization
1301 East Debbie Lane Suite 102 #615
Mansfield, TX 76063
Phone: (512) 298-4786
Fax: (888) 507-6912
Email: manager@truedecisionsiro.com

PATIENT CLINICAL HISTORY [SUMMARY]: X with a date of injury X. X was working as an X. Following the X accident, X complained of X. X was diagnosed with X. On X, X had a follow-up visit with X, MD. X presented for X pain and to discuss the denial of X requested X. X symptoms had not changed since the prior visit. X was X with pain. X had not improved with X. X reported that X had not tried X pain. X also had X after the injury. The X pain was located X. The pain was exacerbated by X. The pain was rated X. X was on X mostly doing X work. The X showed X degrees, X degrees, and X to the X. There was positive X, X tests. X was noted at the X. Per the assessment dated X, examination of the X showed X but with some X. An X of the X dated X revealed a X. Treatment to date consisted of medications (X), X. Per a utilization review determination letter dated X, the request for X was denied. It was determined that X had continued pain in the X. According to the guidelines, a X was not recommended as most initial treatment of X. X demonstrated X. X in the form of a X. It was documented that X had to undergo a X. There must also be complaints of pain at X, which was not documented. The request for a X was not certified. A letter dated X indicated that the reconsideration request was non-certified. Rationale: "This request was previously denied as there was no evidence the claimant X. In this case, claimant has attempted X. On examination, there was X. The X was X. X on independent interpretation by the treating provider revealed X. However, there is no documentation a X has been completed as the ODG recommends a X prior to proceeding with X. Medical necessity has not been established as this request exceeds the guidelines."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The ODG supports X. Guidelines support X intervention for X. The X as indicated when a history, physical examination, and imaging are indicative of significant X

and there is been a failure of X. The documentation provided indicates the injured worker has complaints of X pain despite X. A physical examination of X documented X. An X documented an X. The provider has requested a X. Based on the documentation provided, the ODG would not support the requested X as there has not been a documented trial and failure of a X. Additionally, there is no documentation of X on imaging to support X. While there is X documented, is unclear why a X would be indicated for this injured worker.
Given the documentation available, the requested service(s) is considered not medically necessary and therefore, the decision is upheld.

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