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. X was putting together a X. While putting the X. X. The pain had been persistent for X. X was diagnosed with X. On X was seen by X, MD in an office visit. Since the X. X also reported X pain X. X would sometimes become X. Examination revealed X. X had a X. X had tried X for pain. X had also completed X. An X of the X and X were ordered. X was currently out of work. X of the X. Prior diagnostic included X of the X which showed X. There was a X. X of the X revealed X. There was a X. There was no evidence of X. Treatment to date included X. According to the Utilization Review dated X, X, MD denied the request for X of X. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, X is recommended as a X option following at least X weeks of X. X is not a substitute for X , so referral should always be supported by clear documentation of X. X may be useful to obtain X evidence of X following at least X weeks of X, although it is not necessary when X is clinically obvious by experienced X. X are not recommended, and there is minimal justification for performing X. In this case, the patient presented with X pain. X had X. X had shooting pain X. X had X. Examination showed X. Prior X in X showed with X. A request for X to X. However, the specific objective neurological findings were insufficient to fully necessitate the request. Provocative tests and objective quantifiable assessment of reflexes were not documented. Furthermore, there was also limited objective evidence that the patient had at least X weeks of X prior to considering the request. Exceptional factors were not established. As for the X for X are not necessary to demonstrate X, they have been suggested to confirm a X. While X is not recommended to demonstrate X. In this case, X. However, the patient had X on X. Moreover, there were limited significant X to support a repeat study could not be clearly established in the records, there was no documentation that the patient

was a candidate for X. Clarification is needed regarding the specific indication / rationale of the request and how it might change the treatment recommendations as well as the patient's clinical outcomes. Clear exceptional factors could not be identified." A letter by X, PA-C / Dr. X, dated X, appealed the denial of the X. Per a Reconsideration Adverse Determination letter dated X, X, MD upheld the original denial. Rationale: After careful review of all available information, our Texas Licensed Utilization Review Physician has determined that the proposed treatment does not meet medical necessity guidelines. We are unable to recommend the proposed treatment based on the following: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The provider did not demonstrate X for this patient.

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

The stated reason for the X in this case is "to look for X." There are insufficient clinical findings which would support the need for X. There is insufficient evidence to support "Development of a differential diagnosis by the X, based upon an appropriate history and physical examination performed by the physician." X are not medically necessary for this patient's condition.
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:

☐ 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