True Decisions Inc.

Notice of Independent Review Decision

True Decisions Inc.

An Independent Review Organization
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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

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who was injured on X, when X. X was diagnosed with X. On X, X was seen by X, MD for injury to X. X reported pain and X. X examination showed X. X had X and was able to X. X was X. X was treated with X. X was allowed to X. On X, X was evaluated by X, for X. X reported X. Examination showed X. On X, X performed X to determine if X. X continued to X. X showed X. X were X. X determined that X would X. Treatment to date included X. Per the Utilization review dated X, the preauthorization request for X was denied by X. Rationale: "ODG X online version X. Recommended as indicated below. Not recommended for patients with X. The patient is X individual who sustained an injury on X. The patient was diagnosed with X. Based on medical criteria X is not indicated as X is not recommended for patients X. The requested X is not medically necessary. "Per the reconsideration review dated X, the appeal for X was not certified. Rationale: "In this case, the history or recent physical examination findings did not indicate X. The records provided did not specify X. Details regarding X were not specified in the records provided. Therefore, the request is recommended 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. Per the Utilization review dated X, the X request for X was denied by X. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There are no significant findings documented on physical examination to support X at this time. The patient's physical examination notes normal X. Report of medical evaluation dated X indicates diagnosis is X. The patient was determined to have X.
Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

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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