True Decisions Inc.

Notice of Independent Review Decision

True Decisions Inc.

An Independent Review Organization
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Amended Letter

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 sustained an injury on X. X sustained X while X. X and X. The diagnosis was X. On X, X underwent X. X had X. X did X. X had difficulty X. It was noted that X had X. When X, X used X. X performed X. The results showed that X. A note from X dated X indicated that X. X had X but X. Treatment to date included X. In a letter dated X, X, stated: X." On X, the request for X was denied. The reviewer stated: "ODG does recommend X for the documented injury X. The provided documents do not indicate X. further there is no documented limitation that would prevent the patient X. Lastly, the attending provider does not conduct peer to peer and additional information was not provided. For these reasons, the requested X is denied." On X, the appeal request for X was non-authorized. Rationale: "The claimant has already X. I would also note that the current request just by itself exceeds the guideline recommendations. It is being suggested that X is necessary prior to X. The clinical record does not support such. I note that there were X. This had mainly to do with X. It was reported that X had no X. X had X. Thus, at this point, X. The provided documentation does not support further exceeding the guideline recommendation."

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 X is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The request for X would continue to exceed guideline recommendations. When treatment duration and/or X exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of X. There are no X to X. The patient has X and should X with 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