True Decisions Inc.
An Independent Review Organization
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IRO REVIEWER REPORT

Date: X

IRO CASE #: X

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 who was injured on X and X. On X, X was X. On X, X was X. X was diagnosed with X. On X, X was seen by X, MD for X. Since the injury, X had developed X. X reported X. The X. X reported the X. X had X. X complained of a X. X demonstrated X on X. On examination of the X. The X was X. The X was intact without X. The X was aerated with X. The X. On X examination, there was X. There was X. The X was X. The X of the unspecified body part documented an X. There were X present. There was no X identified. A letter dated X by X, X documented X was seen for a complete X evaluation on X. X testing revealed X. X was X. The X. X revealed X for X. X Testing was also conducted, and X. At the time, X was examined by Dr. X, and stated that since X injury, X was X. Dr. X recommended X. Those X had different X. A letter on X

documented the initial request for X was denied due to an incomplete peer-to-peer meeting with X physician. At the time, the peer-to-peer was initiated, Dr. X was out of the office and unable to return the call. A CT scan of the X was performed on X, and it was X. An MRA of the X was performed on X and was X. An MRI of the X was X. The treatment to date included medications X. Per an adverse determination letter on X by X, MD, the request for X was not medically necessary and was noncertified. Rationale: "Based upon the medical documentation presently available for review, Official Disability Guidelines (ODG) would not support medical necessity for this specific request as submitted. The records available for review do not identify the presence of a specific X. Attempts at conducting a PEER-to-PEER review were not successful. Presently, the medical necessity for this specific request as submitted is not established. There are instances whereby the above-noted reference would support the consideration of the utilization of X. However, based upon the medical documentation available for review, presently, medical necessity for this specific request as submitted is not established." Per a letter dated X by X, AuD, the initial request for X was denied due to an incomplete peer-to-peer with X physician. At the time the peer-to-peer was initiated, Dr. X was out of the office and unable to return the call. Per an adverse determination letter by X, MD dated X, the request for X was not medically necessary. Rationale: "ODG does not address the request specifically. As per evidence-based literature, attention to the use of X devices should be personalized, taking into account the needs of each individual, considering not only the attenuation but also the user's reported well-being. There was a previous determination dated X, where the request was non-certified because the records available for review did not identify the presence of a X. In this case, the patient suffered X. Workup included a X exam and a X. The patient is not documented to be in X. The records do not identify the presence of a X. Presently, the medical necessity for this specific request as submitted is not established. As such, X is not medically necessary."

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

The patient has noted X after the injury. In order to facilitate a return to work the use of X is justified and medically necessary.

Therefore, it is this reviewer's opinion that medical necessity is established and the prior denials are overturned.

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

NA