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

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: Pain Medicine

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 X. X was X. X had developed X. X was diagnosed with X. X underwent X. X demonstrated the ability to X. X could X. X had X. X were X and X. X was evaluated by X, MD on X. X was X and developed X. The X had X. X continued to have X. It X. It went X. X had X. Examination of the X. X was X. X had some X. Dr. X opined that. X had significant X. X recommended a X. X was seen by X, MD from X. On X, X presented for X. X could X. The X. It was X. On X, X presented for a follow-up of X, which X. The was X. The symptoms were X. On X, X ongoing X. The X was X. X test was X. An MRI of the X, which X. There was X with X. At X, there was X. There was an X. There was X. At X.

Treatment to date included X. Per a X decision letter dated X and X dated X, the request for X was denied by X, MD. X: "In this case, there is no documented evidence of X. The X is also X. Furthermore, no X reports were submitted for review. Therefore, the request for X is not medically necessary." Per an adverse determination dated X and X review dated X, the prior denial was upheld by X. X: "Based on the documentation provided and per the X, the requested X is not considered medically necessary. In this case, though the claimant has a history of X with X, there were no documented X on examination to support the requested X. The claimant had presented on X and reported X. X were noted. Given there were X on examination to support the requested X, the request is not considered medically necessary in this case. Therefore, the request for X is not medically necessary."

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 for Other Procedures is not recommended as medically necessary, and the previous denials are upheld. Per a X decision letter dated X and X dated X, the request for X was denied by X, MD. X: "In this case, there is no documented evidence of X. The X is also inconsistent with X. Furthermore, no X were submitted for review. Therefore, the request for X is not medically necessary." Per an X dated X and X review dated X, the prior denial was upheld by X. X: "Based on the documentation provided and per the X, the requested X is not considered medically necessary. In this case, though the claimant has a history of X, there were no documented X on examination to support the requested X. The claimant had presented on X and reported X. X were noted. Given there were X, the request is not considered medically necessary in this case. Therefore, the request for X is not medically necessary. There is insufficient information to support a X in determination, and the previous non-certifications are upheld. The patient was recently participating in a X which X. The patient's X to establish the presence of X. There is no significant X documented on X MRI.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and 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