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

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: Anesthesiology

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. The X was not available in the records. On X. X had X. X was X. The X. The X. X had X. The pain X. X were X. X were X. X to the X and X. On examination, X. X had X. X had X. There were X. X was X. X of X. X had X. On X presented to the X. X had been to X. X of X. X stated X. X did X. X had X with X. X stated at X and X noticed that X. The X. The X and X the X. The X with X and X, and X. Treatment to date consisted of X. Per a utilization review dated X, MD denied the requested service of X. Rationale: "ODG-X notes that X. X are X for X. X is required with a X. The pain X. X should be X. There should be X. In this case, the requested procedure does not meet the guideline criteria. The documentation does not support X. As such, recommendation is to deny." Per a Utilization Review dated X, MD non-certified the requested X. Rationale: "Per ODG, "Approval depends on X may be required, they should not be X. Duration of X. Current X does not support X." In this case, the X is not documented. Objective X are X. Furthermore, current examination reveals X. Finally, ODG guidelines do not recommend this X. The request for X is not shown to be 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 is not recommended as medically necessary, and the previous denials are upheld. There is X in determination, and the previous non-certifications are upheld. The patient's X is not documented. Additionally, the patient is noted to have a X.

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

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