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:
Board Certified 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 sustained an injury on X. The diagnoses included X and X. X complained of X. The pain was described as X. X reported X. The pain was X. The pain was X. The pain was X. The X was X. There were X. X and X. The X was X. The X to X. X was noted as X. X was X. A X evaluation was performed by X, PhD / X, PhD on X. X did X. Additionally, X assessments did X. Regarding the X. X was X. X to have a X. Based on the evaluation, X predicted the X. An MRI of the X showed X. X-rays of the X was non-certified. Rationale: "The documentation X, including X. Hence, the requested X is not medically necessary. Per ODG, before moving forward with an X, there must be a X, which has not occurred. Hence, the requested X is not medically necessary." An appeal letter on X, MD documented X disagreed with the denial. X presented to the clinic for a X. X was status X. X complained of X. X would like to X. Based on X clinical situation, other potential options for treatment were considered, and the clinical evidence supported the use of X. The provider believed that was the best treatment for X at that time and therefore should be a covered benefit based upon medical

necessity. Per a peer clinical review report by X, MD, on X, the request for X was non-certified. Rationale: “I recommend non-certifying the request for an APPEAL: X based on the following: The available documents indicate X. The claimant has X. A X noted that X was a X. Guidelines may support X when specific criteria are met, including a X and X. Until the above is completed, the medical necessity for a X cannot be justified. Therefore, my recommendation is for non-certification.”

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

The claimant presents with X. The claimant’s X is X. The claimant did have an X. The claimant had X. The claimant was X. In this case, the claimant X. The previous denials focused on the X is reasonable for this claimant. As the claimant’s meets the clinical indications for the X on current evidence-based guideline recommendations, it is this reviewer’s opinion that medical necessity is established and the prior denials are overturned.

The claimant presents with X. The claimant’s X. The claimant did have an X which had X. The claimant had X. The claimant was X. In this case, the claimant X. The previous denials focused on the X such as X which is immaterial to determining whether the X. As the claimant’s meets the clinical indications for the X based on current evidence-based guideline recommendations, 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