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: X

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X with date of injury X. The biomechanics of the injury was not available in the records. Diagnoses included X. On X presented to X. X reported X. Pain X. Pain X. X was X. X had a X. According to X. The X was X. It was X. It X. Examination revealed X. X, ANP evaluated X for X. Pain radiated X. X reported that X. X saw Dr. X a X, and X was advised to have the procedure re-submitted, but if it was denied again, X would request an independent board review. X was dependent on X. X had a X. A X showed X. A X with X and X. Treatment to date included X and X. Per a utilization review by X, MD on X, the request for X was non-certified. Rationale: "The claimant presented with X. Evidence-based guidelines do not recommend X. No exceptional factors are noted in this clinical scenario. X, this request is not medically necessary." Per a utilization review dated X by X, MD, the request for X was denied. Rationale: "Not recommended in the X. None of the following are recommended: X. Pain due to X. X in this X. Recommendation for any X. In addition, X. There are no documented extenuating circumstances to support an exception to the guidelines. Therefore, the request for Reconsideration 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 is not recommended as medically necessary and the previous denials are upheld. Per a utilization review by X, MD on X, the request for X was non-certified. Rationale: "The claimant presented with complaints of X. Evidence-based guidelines do not recommend X. X are noted in this clinical scenario. X, this request is not medically necessary." Per a utilization review dated X by X, MD, the request for X was denied. Rationale: "Not recommended in the X. None of the following are recommended: X. Pain due to X. X in this region also X. Recommendation for any X procedures cannot be made due to X. In addition, X is recommended at X. There are no documented X. Therefore, the request for Reconsideration Request for X, is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines note that X is not recommended in the X. Pain due to X. X in this region also presents X. Recommendation for any X. Additionally, the request for X exceeds guidelines which note that no more than two levels should be performed.
Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the request 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