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

Notice of Independent Review Decision

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:

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who sustained an injury on X. X, X where X. X sustained a X. X was status post X. X was diagnosed with X. X was seen by X, PA / X, MD on X for a follow-up of X. X worked as a X and did not X. Medical records indicated a witness stated that on X. X was taken to X Medical Center and was diagnosed with X. X subsequently underwent a X. X had X while X. X continued with X, X and X. X complained of X due to X. X also had X as a result of X. X was accompanied by X and X whom X had X for X. X was X with X and X and X instead of X. X could X but X was a X for X and X. X expressed concern over X. X was notable for a X and evidence of X. The X showed X. X and X were X. X was referred to X for X. Per note dated X by X, PA, X sustained a work-related injury on or about X. X was diagnosed with a X. X subsequently underwent a X. X had continued with X and X. X apparently had X while in the hospital. X would need X and X. X could X and would not need X. X would benefit from X and X that would be reasonable and medically necessary to address X injury. On X, X wrote on

behalf of X to appeal the X decision to deny X for X for X, X stated, “X.” On X, X was seen by X, MD for X and X. X had X and X in the X. X noticed that after the X injury that X. X felt the X and X had no X prior to X. X felt X had some X prior to X. The X had a quality of X. When X, X felt X. It was X when X. X had to X and X. X felt like X if X. On examination, the X. X demonstrated X. X demonstrated X. On X, X returned to visit X for a follow-up. X reported X. X underwent X. X continued to have X. On examination, X appeared X. A X was noted X. On X, X, SLP / X, SLP saw X for X evaluation. X reported on X after X, X was diagnosed with a X. X underwent X on X. X hospital course was complicated by X, for which X received a X. While in the hospital, X had a X. X had X. X was X for a X yet did have X. X also presented with X. X was due to X. Following discharge from the hospital, X was X. Treatment to date included X. Per notice of adverse determination by X, DO on X, the request for X was non-certified. Rationale: “This is a X patient with date of injury (DOI) of X where X sustained a X. It is noted that X was subsequently diagnosed with X for which X underwent a X. It is noted that X developed X. Treatment to date is noted to include X. Clinical documentation of X progress notes indicates that X. The patient needs assistance with X. The patient had also been referred for X. The patient's social support is documented as X, whom X. It is noted that X, but can X. The current request is for X. ODG guidelines justify the medical necessity of X requires documentation of the medical condition that necessitates X. There are also requirements of documentation for the expected kinds of services that will be required, with the exception of tasks and services that can be performed without X, with an estimate of the frequency and duration of such services not to exceed X. The submitted documentation does not indicate expected services to be rendered by X. Based on the review of guidelines and clinical documentation, the recommendation for the request is an adverse determination. Per review by X, MD on X, the request for X was non-certified. Rationale: “The claimant is X. X is noted to be X. Some level of X appears reasonable but, it is not clear what X as the last updated examination does not detail X. It has been X since X last assessment. Based on the documentation available for review, medical necessity is not established. Recommend non-certification for X.” A letter by X, RN dated X documented X was previously employed by X. Their X consisted of X. X was X.

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 insufficient information to support a change in determination, and the previous non-certifications are upheld. The duration of the request is not specified. The specific medical treatment to be provided is not specified. ODG guidelines justify the medical necessity of X requires documentation of the medical condition that necessitates X, including X. There are also requirements of documentation for the expected kinds of services that will be required, with the exception of X, with an estimate of the frequency and duration of such services not to exceed X. The submitted documentation does not indicate expected services to be rendered by the 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