True Decisions Inc.
An Independent Review Organization
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Notice of Independent Review Decision

IRO REVIEWER REPORT

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 X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who was injured on X. The injury occurred when X was X and X causing injury to X. Diagnoses included X. On X, X was seen by X, X visit for X. The pain level was X. X reported that X at the X. X was X due to X but performed X and X. X continued to suffer from X, which X. The pain was X by X and somewhat relieved with X. A X dated X revealed X. X continued to report X and was interested in X. On examination, X, X without X. Treatment to date included X. Per a utilization review adverse determination letter dated X and Physician Review Recommendation dated X, the request for X was denied by X, MD. Rationale: “In this case, X is attributed to X. This was confirmed in a case discussion with X, NP. There are no documented X to support an exception to the guidelines, which do not recommend X to X, Therefore,

this request Is not shown to be medically necessary and is not certified.

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-certification is upheld. There is no documentation of recent or ongoing active treatment X. There are X. There is no X submitted for review. There is a lack of support for the requested procedure within the guidelines for the patient's diagnosis.

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