True Decisions Inc.
An Independent Review Organization
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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:

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

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who was injured on X. The mechanism of injury was not available in the provided records. The diagnosis was X. X presented for follow-up on X to X, MD. X continued to have X, which allowed X to be more X. X reported X did not receive X even though X was X. X was at the time following up with X and X that recommended X. X reported X was, at the X. X stated X would X. X would X. On examination, X. The X was X. X utilized X. The assessment was X. X was X. Treatment to date included X. Per a utilization review adverse determination letter dated X, X, MD denied the request for X. Rationale “The proposed treatment consisting of X is not medically necessary. The objective evidence of X and X to determine X was not established to support the X. Therefore, the proposed treatment consisting of X is not medically necessary. Due to the nature of this X, X is recommended.” Per a reconsideration

/utilization review adverse determination letter dated X, DO denied the request for X. Rationale: “In accordance with prior denial, "The objective evidence of X and X to determine objective efficacy from X use was not established to support the X." This statement still characterizes the documentation provided for this case. Documentation does not indicate the X. It is unclear if X is X to X or from X. Additional documentation was not provided for review since prior consideration. Medical necessity for X has not been established. Given the above, the request continues to be non-certified. Due to the nature of the X, X is recommended.”

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

The request for X and X were reviewed. Dr. X has noted X provided X. As the patient has X the request should be certified, so the patient will have a chance at X and have X.

The request for X is supported as medically necessary in my opinion.

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