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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X who sustained a X while X. The diagnoses included X. X was seen by X, MD on X. X reported X. X was X. X re-evaluation was performed by X, PT on X. X documented a X. X and X. X had a X. X reported X. X with X. X stated that X. X was X was X and X. The X and X. The X. The X and X. A X note on X reported a X and X. A X note dated X documented X. X was noted to have X. Treatment to date included X. Per a peer review dated X, the request for X was non-certified by X, MD. Rationale: "It appears the X. ODG allows X. The submitted documentation X. Therefore, the requested X is not medically necessary." Per reconsideration review dated X and peer review dated X, the prior denial of X and X was upheld by X, MD. Rationale: "The requested X is not seen as medically necessary as the request greatly exceeds the guideline

recommendations. The records provided X which would X of guideline recommendations rather X. ODG-TWC allows X and X. The claimant has a X. The claimant more X. It is noted that the claimant has X. At this time, the request greatly exceeds the guideline recommendations. The records provided do X recommendations rather than X. As of X, it is noted that the claimant has an X. As of X, the claimant is noted to have X. Considering the claimant's X. Medical necessity of this request is not established."

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

The claimant X. The claimant had continued with X. As of X. The most recent X did not include X. The records did not include any X. The X clinical report X. At this point, it is unclear how X.

Therefore, it is this reviewer's opinion that medical necessity is not established for the X.

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