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:

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 an injury on X while X. The diagnoses included a X, and X. On X, X was seen by X, X for X. X presented with X. The pain was described as X and X. It was X. X continued to have X and X. It was X and was X. It was X. It was X, and X. X was X. On examination, there was X. There was X. X of X, and X. X in X, X and X. X and X. The X was X. X was seen by Dr. X, MD on X for the X. X attended X, X was seen by Dr. X for X. The pain was described as X, and X. It was X. The symptoms had X. X stated X was X. X reported that X had X. X was doing X. X revealed X. X had pain with X. X and X was X. X had X and pain with the X. X included X. Treatment to date included X. Per a peer review by X, MD X, the request for X was non-certified. Rationale: "The claimant has had X, i.e., treatment in X recommended in ODG's X for those with X, i.e., the diagnosis reportedly present here. ODG further stipulates that the frequency of treatment should be X, as claimants transition to X and also notes that X. Here, the

request for continued treatment at a rate of X with the ODG X. X and X, the treating provider acknowledged on X. All of X, suggested that the claimant has likely X. It does not appear likely that the claimant can X. Therefore, the request for X and X is not medically necessary." Per a peer review by X, MD on X, the request for X was non-certified. Rationale: "Understanding the date of injury, noticing the mechanism of injury, given that there is no clinical data presented in any of the records provided suggesting any efficacy or utility with the X already completed there is no clear clinical indication to repeat this otherwise X. Furthermore, after speaking with X, the X stated that the patient has had X. This is a X that is more X. The patient is X. Dr. X stated that is a X. The patient needs some X. The patient was given X. The patient X the criteria per guidelines. Provider relied that there is X indicated for this situation. Patient has been instructed on a X and it would be best to follow that to X. Therefore, all of the above requests are not supported."

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 and treatment of the X: X to develop X: Use of X to X. Examples of such X etc., 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 submitted clinical records indicate that the patient has X. The request for X would continue to exceed guideline recommendations. When treatment X the guidelines, exceptional factors should be noted. There are no exceptional factors of X documented. The patient has X and should be X.
Based on the evidence submitted, medical necessity is not established.

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