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

Amended Letter

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. X was X and X. The diagnosis was X, X and X. Per Clinical Encounter Summary by X, MD dated X, X presented with X. X underwent a X to assess for X. X had a significant amount of X that X, but per X description X had a X. X now complained of X that X. X rated X. Review of systems was notable X. On X of the X, there was X and X, X, and X. X was X and X, otherwise X in all X. X to X. X and X were X. There was X / X / X. There was X. There was a X. There was no X, and X. Per assessment/plan, X was recommended. X of X by X, MD dated X showed an X. X was not X. There was X or X were seen. X for X was recommended. X as X for this exam with X. There was X, X. Treatment to date included medications X, and X on X.A Notification of Adverse Determination dated X indicated that the request for X was

non-certified. Rationale: “Per evidenced-based guidelines, X is recommended as indicated for carefully selected patients with proven X, following X. In this case, X was requested; however, documentation of significant X and X was not fully validated upon comparison of findings. In addition, detailed objective evidence that the patient had X and X, X, X, or X was not completely established in the medical records submitted to consider the request. Furthermore, guideline indicated that this procedure should support an evidence-based X. On X, a Notification of Reconsideration Adverse Determination indicated that the reconsideration request for X, under X was non-authorized. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. This X the on X. No mechanism of injury is clearly stated. The reported condition is considered X because X have X since the X. The following criteria were satisfied: the X; the patient has X. The request is NOT certified because the following criteria were not satisfied: the X does not include sufficient information to rule out a X; there was no objective evidence that the patient was X such as X, and X; there is evidence of a clinical X. In the peer-to-peer discussion, the requirements of the Guides were reviewed with the provider (or designee). The deficiencies in the request were discussed, and the reasons for non-certification were given. Since a successful peer-to-peer conversation has taken place, no additional clinical information is expected to be provided. The documentation provided for this request is either NOT significantly different from the original request OR does not adequately address the objections from the previous reviewer.”

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 recommended as medically necessary, and the previous denials are overturned. The submitted clinical records indicate that the patient underwent X on X and reported X and X. The patient presents with X on exam. X has undergone X and continues with X. Medical necessity is established in this case 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