True Decisions Inc.

Notice of Independent Review Decision

Case Number: X Date of Notice: X

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

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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 involved in an accident X. The diagnoses were X. On X, X was seen by X, MD for X. X underwent X, which showed X and X was recommended X. X had X. X saw X who felt X was X and X. X was X but X. X continued to have X. X rated X. X felt like X was X. The X and X felt X with X. X had X. The X had X. X showed X and X. The examination revealed X. X dated X showed X. No X or X was noted. X dated X showed X. There was no X or X. X dated X showed X noted. No X was noted. X was seen by X, X on X. X reported X in the X and X. X rated the X. The symptoms were X. X reported X was X with the exception of X. X reported X in the X was X and X was X. X on X was X and X was X and X was X and X was X. X on X was X and X was X. X was X and X was X. There was X. X was X and X were X. On X, there

was X in the X and X. X was with X and X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was not certified. “According to the Official Disability Guidelines, the request for X is not fully supported. The information provided for the review did not specify X to date to confirm that the request for X would not exceed the guideline recommendations for treatment. The physician did not elaborate on the extent of the claimant's X to determine why a X would be X. The evidence-based guidelines support X for claimants of X. Based upon the provided documentation, the current request cannot be authorized. As such, the request for X and X, X, as X is not medically necessary. Per a Letter of Medical Necessity dated X, X, X documented that X was being seen for X. X was having X as a result of presenting X. X had a X. X did show X with X from the initial evaluation. X was on X and would X from X in order to improve X. X would like to X; however, was X at the time and X the X. X emphasized on X, so that X would X. X received X to X. X had X all of which were necessary for X. In summary, X were medically necessary in order to maximize X. X required X along with X. X were necessary in order to X. X goals were X. X would X from a X to determine the X. Per a reconsideration review adverse determination letter dated X, the request for X was not certified. “Based on the clinical information provided, the X is not recommended as medically necessary. The initial request was non-certified noting that "According to the Official Disability Guidelines, the request for X is not fully supported. The guidelines recommend X to treat a claimant with X. The total number of X completed to date was not specified within the provided documentation. Additionally, the claimant's X was not verified with any clinical records to determine the extent of X attributed to prior X. The physician will need to provide further information regarding the extent of the claimant's X and explained why X requires X over X to address any remaining X. Given the lack of information regarding prior X, the current request cannot be authorized." There is insufficient information to support a change in determination, and the previous non-certification is upheld. There are no X notes submitted for review to address the issues raised by the initial denial. Therefore, medical necessity is not established in accordance with current evidence based guidelines.”

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

Per a reconsideration review adverse determination letter dated X, the request for X was not certified. There is insufficient information to support a change in determination, and the previous non-certification is upheld. There are no X notes submitted for review to address the issues raised by the initial denial.

Therefore, medical necessity is not established in accordance with current evidence based guidelines for the request for X.

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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