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 sustained an injury on X. X, X and X. The diagnosis included X. X was seen by X, MD on X for X, X, and X. X sustained a work-related injury to X on X. X, X and X. X complained of X. X rated the pain X. X had more pain with X. X examination showed X. X test was X. There was X. X was X. X showed status X. X were consistent with X. An X of the X dated X demonstrated findings X. However, X in that region X. X were X with X. There were X of X throughout the X without X. X was noted. X-rays of the X dated X identified status X with X. Treatment to date included X. Per a utilization review by X, MD on X, the request for X was non-certified. Rationale: "The request for X is being recommended for noncertification at this time. As such, the associated X would not be indicated. Therefore, my recommendation is to NON-CERTIFY the request for X." Per a utilization review by X, MD on X, upheld the denied request for

X. Rationale: “Based on the clinical information submitted for this review and using the evidenced-based, peer reviewed guidelines above, this request is not certified. The ODG by MCG recommends X. As with any treatment, if there is no X after X, treatment protocols should be modified or re-evaluated. Allow for X. X: X: X over X. The appeal X request in this case has been considered not medically necessary and as such, this associated request cannot be substantiated. Additionally, this request has been previously denied in peer review on X and it is not apparent that significant new information has been submitted to support this X the previous determination. The recommendation is for non-certification.”

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

The ODG recommends up to X following X.

As X has been found to be medically necessary, X is medically necessary.

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