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 is a X with a date of injury X. The mechanism of injury was described as X. X. X was diagnosed with X. X was seen by X on X for X. The X was described as X. It was rated at X. The symptoms were X. X reported X and X. On examination, X was X. X appeared in X. X was noted. The X was X. The assessment included X. Treatment plan included proceeding with X. Per an encounter assessment dated X, X continued to have X. A trial of X was provided. Treatment plan remained essentially unchanged. X of the X was obtained on X. The study showed X at X. X was noted at X. There was X. There was X and X at X. This X on the prior examination of X and may have X since studies of X. The poorly scanned medical record was partially legible. Per a utilization review decision letter dated X, the request for X at X with X was denied by X. Rationale: “Official Disability Guidelines states that X are conditionally recommended as a short-term treatment for X with corroborative findings of X. The progress note

indicated the claimant had X. The claimant reported X and X. On X examination, it was noted the claimant had X due to X, no other findings were listed. It was noted the claimant has not participated in X, and the previous X provided a X for an undetermined about of time. Per guideline, there is no documented evidence of X findings, or recent symptom X associated with X. The claimant has not X, as no X has been done. The X did not provide X. It was unknown what procedures or what is meant by X. As such, the request for X is non-certified". Per an attorney appeal letter dated X, "the claimant's symptoms are X, and the attached medical record(s) establish the clinical indication and necessity of this X. The goal of this reasonable and medically necessary treatment, which is consistent with the ODG, is to provide X. Per an adverse determination letter dated X, the prior X was upheld by X. Rationale: "The Official Disability Guidelines only support X if there are X symptoms that correlate with examination findings and X studies. X examination of this injured employee does not reveal any X. This normal examination was also noted in the previous review, Furthermore, there is no documentation of previous treatment with X and it is unclear X had lasted. Accordingly, this request for X is not supported. Recommend non-certification for X". Treatment to date included X on X with X.

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

The request for X was reviewed. X would agree with the previous denials noting a lack of objective findings on examination to support this request. Imaging has noted X. The claimant is reporting X and X, but examination findings are largely limited to X. The clinical records provided do no clearly document examination findings in support of X symptoms and previous benefits from X and X are not noted.
Given the documentation available, the requested service(s) for X is considered not 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