

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

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

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:

- Overturned Disagree
 Partially Overturned Agree in part/Disagree in part
 Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. There was no mechanism of injury available in the provided medical records. Please note, no office visit was available in the provided medical records. X-rays of the cervical spine dated X revealed X. There was X. The X. X was seen which was suggestive of paravertebral muscle spasm. There was X. No evidence of X was found. X-rays of the right shoulder dated X. X was seen. X-rays of X. X-ray of X. There was X. X was noted. An MRI of the X. There was X. X were noted. There was X. X were to be considered. There was X. X was seen involving the X. This was a nonspecific finding that may be X. An MRI of the X. There was X. There was X. There was X. A X was seen, which X. There was grade X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The ODG by X. In this case, the worker X. The worker takes X. The pain was rated as X. The physical examination revealed knee extension -X degrees and flexion to X degrees. Unfortunately, it is unknown what objective improvements were noted from the X. In addition, it is unknown what barriers exist in transitioning the worker forward to a X. Therefore, the request for X is not warranted. As such, the request for X commas recommends for noncertification. "Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The ODG by X. In this case, the worker has X. The worker takes X. The pain was rated as X. The physical examination revealed knee extension X degrees and flexion to X degrees. Unfortunately, it is unknown what objective improvements were noted from X. In addition, it is unknown what barriers exist in transitioning the worker forward to X. Therefore, the request for X is not warranted. As such, the request for X, is recommended for noncertification. "The requested X is not medically necessary. The submitted records do not demonstrate what improvements have been made with the X. It is not clear as to why the patient cannot transition to a X. As such, X is not indicated. X : X is not medically necessary and non certified

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

The requested X is not medically necessary. The submitted records do not demonstrate what improvements have been made with the X. It is not clear as to why the patient cannot transition to a X. As such, X is not indicated. X quantity: X is not medically necessary and non certified

Upheld

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