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09/12/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

DO, Board Certified Neurosurgeon

REVIEWER OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XXXX who was injured on XXXX. The claimant had been assessed with a XX and XX-XX symptoms. The XXXX EEG study was XX. No other diagnostic studies were submitted for review. The claimant's medications had included the use of XXXX. The XXXX evaluation noted persistent XX with temporary improvement from injections. The claimant described some improvement in XX symptoms. The physical exam noted restricted range of motion of the XX XX with tenderness to XX in the XX region. There were no XX deficits. The XX study was denied by utilization review as there was limited rationale provided in the records to support the testing for a patient with typical post-XX symptoms and no evidence of XX activity.

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

The provided records did demonstrate a typical presentation of post-XX syndrome. The claimant's provided EEG studies were normal. There were no XX deficits evident as of the XXXX evaluation. The claimant had no reported or witnessed XX XX. The XXXX letter of medical necessity stated the XX study was to evaluate for possible XX activity due to the injury;

however, with the prior EEG study being normal and the claimant's clinical findings completely negative for any concerning XX findings, it is unclear how a XX study would impact treatment recommendations for the claimant's current condition. Therefore, it is this reviewer's opinion that medical necessity for the request is not established and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**