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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Cover sheet and working documents
Letter of request for preauthorization of treatment X
XX assessment X
Clinical note X
Functional capacity evaluation X
Treatment plan undated
Letter of request for reconsideration of preauthorization X
Request for independent review (Workers' Compensation) X
Request for a review by an independent review organization X
Notice of adverse determination X
Appeal request denial X
IRO request details X
Notice of assignment to independent review organization X
Notice to utilization review agent of assignment to independent review organization X

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X year old X whose date of injury is X. The mechanism of injury is described as X. Office visit note dated X indicates that the patient has had continuous X pain which radiates daily down the X in the X distribution. On physical examination X has X and X. There is decreased range of motion of the X. X is negative. Clinical impression is X with multiple X findings in the X. Authorization request dated X indicates that treatment to date is noted to include X, X, X and X. X assessment dated X indicates that X is X and X Scale for X is X. Current medications are X, X, X, X, X, X, X. Pain averages 7-10. Functional capacity evaluation dated X indicates that current X is sedentary and required X is XX. The patient is currently not working. Medical history is positive for X, X, and X surgeries. Diagnosis is X and X factors affecting other medical condition, moderate.

The initial request was non-certified noting that the submitted clinical records fail to establish that the patient has X of care and is an appropriate candidate for this X program. There is no documentation of any recent active treatment. There is no

documentation of any X. It is unclear if the patient has a job to return to at this time. The patient's date of injury is over X years old which is a relative contraindication to the program. Therefore, medical necessity is not established in accordance with current evidence based guidelines. Reconsideration request dated X indicates that X is not currently a treatment option based on the insurance carriers filing of an extent of injury dispute which limits the accepted compensable injury to X. No other treatment options are under consideration other than the treatment in question with the request. The denial was upheld on appeal noting that according to guidelines, the patient has been continuously X for greater than X, the outcomes for the necessity of use should be clearly identified as there is conflicting evidence that X programs provide return-to-work beyond this period. The outcomes for the necessity was not clearly documented as recommended by guidelines and there were no exceptional factors provided to support this request beyond guideline recommendations.

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

Given the current clinical data, the request for X management XX X hours is not medically necessary, and the previous denials are upheld. It is unclear if the patient has undergone X testing with validity measures to assess the validity of the patient's subjective complaints. There are no serial treatment records submitted for review documenting the patient's objective, functional response to treatment. It is unclear why the patient's physical demand level is X given that the patient's accepted diagnosis is a X only. Recommend non-certification and X management XX X hours is not medically necessary.

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

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES