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Notice of Independent Review Decision

PATIENT CLINICAL HISTORY [SUMMARY]: X with date of injury X. On X, X was evaluated by X, MD for the X. The X pain was X. The pain was rated as X. X had more pain with X. The examination showed an antalgic X. X test was positive. X at the X was noted. Soft tissue X was noted. The X showed X. An MRI of the X dated X showed a X likely representing a X, mild X. Treatment to date consisted of medications (X), X. Per a utilization review determination letter dated X by X, MD, the request for X was denied. It was determined as the request for X was not supported, the request for X was not medically necessary. A letter dated X by X, MD indicated that the reconsideration request was non-certified. The consideration was made that the Official Disability Guidelines supports up to X visits of X following the surgical treatment of X. There was no indication of why X initial X visits would be necessary. In addition, as X was not medically necessary, X for the X as an X was not medically necessary.

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

The ODG supports up to X visits of X following X to include X and X. The documentation provided includes a diagnosis of a X with request for an X. Based on the documentation provided, the ODG would not support X. Additionally, the injured worker has not met X.

Given the documentation available, the requested service(s) is considered not

medically necessary and the request is upheld.

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

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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES