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An Independent Review Organization
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Description of the service or services in dispute:
X

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified X

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

X

Patient Clinical History (Summary)

X who sustained an injury X. X had X and X. The diagnoses included X.

X was seen by X, MD on X for a follow-up of X. X had X. X stated X and that X considered X. X described X. X had a X and was X. X had received X. X in the X. X and X. In the X. X with X. X showed X. X exhibited X. The X. The X. X and X. X was seen by X, MD on X. X reported the X. X had been X and X. Since the X. X described that X. X described X. X showed X and X. X and X. X showed X.

Treatment to date included X including X.

Per a peer review by X, MD on X, and a utilization review determination letter dated X, the request for X was non-certified. Rationale: “The documentation provided detailed that X. It was stated that the claimant was X. However, it was X and therefore, authorization cannot be

warranted. As such, the request X is not medically necessary. Official Disability Guidelines states that the X.

In the utilization review determination letter dated X MD, documented that X had a peer-to-peer discussion with X, who informed X that X had X. Dr. X said X was X.

Per peer review by X, MD X and a utilization review determination letter dated X, the request for X was non-certified. Rationale: “Based on the provided documentation and current medical literature, the requested X is not medically necessary. X is considered medically necessary, within the standard of care, and approved by the FDA in the treatment of X. In this case, however, the claimant does not have any of those conditions. Therefore, based on the provided documentation and current medical X is not medically necessary.”

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The requested X would be medically justified and necessary at this time given continued X. X is noted to be X. My determination is based on peer reviewed X. Given the documentation available, the requested service(s) is considered medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐
- ☐ DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ TMF Screening Criteria Manual
- ☑ Peer Reviewed Nationally Accepted Medical Literature (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)