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Notice of Independent Review Decision

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:

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who was injured on X. The biomechanics of the injury were not found in the available medical records. The diagnosis was X. On X, X was evaluated by X, MD. X was X. X included X. The X changed from X and the X was X at the time. X included X. X had X to help X. The X had X and now X. X had X. The symptoms X. The X was X and had X. X had X when X. X included X. On examination, there X. X examination of the X revealed X. X showed X. X examination revealed X. X was X on X. An MRI of the X revealed X. Treatment to date included X. Per a utilization review adverse determination letter X, the request for X was denied by X. Rationale: "Per evidence-based guidelines, X is recommended to patients with X. In this case, the patient presented with X. On examination of X, there was X. There was X. Please note that the X was not quantified. There was X and X. The X examination of X was X. The X were X. The X of the X was X. The X was X. A request for X was made. However, there were insufficient findings to warrant the requested X such as evidence of X. Moreover, there were X to objectively validate the X. There were no X presented in this review. Also, there was no X report for the presence of X. In X office visit note X, Dr. X opined that X again had X, which X. X symptoms and X had X and X. X had X, Dr. X discussed X including X. The X had previously been denied by Dr. X, with the rationale that X. However, the X demonstrated X. Furthermore, there were X. Dr. X also reported there was X. Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X. The principal reason for the determination for non-certification was as follows: "The proposed treatment plan is not consistent with our clinical review criteria. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Given that the patient had X. Also, although it was noted that the patient had X. Furthermore, the actual reports of the X reviewed are needed to objectively verify the patient's X to justify the necessity of the X. Lastly, there was no X submitted to address the X. The prior non-certification is upheld."

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

The claimant has been followed for X at the X. The claimant had X with X. The claimant had X. In review of the X noted X. There was further X at X that X. At X no was noted. X evaluation noted X. The physical exam noted X. There were X. There was X. Based on the clinical findings, the claimant has X. The claimant's imaging did note X. While X could be considered at X, there is insufficient evidence of X that would support X.

Therefore, it is this reviewer's opinion that medical necessity is not established for X

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