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X

IRO CASE #: X

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

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 patient is a X who alleges injury on X, when X was X.

On X, a magnetic resonance imaging (MRI) of the X performed at X and interpreted by X, M.D., showed: X.

On X, the patient was seen by X, M.D., for X. Associated symptom included X. The aggravating factors included X. Previous treatments included X. The X exam showed X. The x-rays of the X showed X. There was X. The diagnoses were X. X, X, X was recommended.

From X through X, the patient was seen by Dr. X in follow-up visits. The patient continued to have X. The X exam showed X. X, X was recommended.

On X, x-rays of the X performed at X showed X.

On X, Dr. X performed X. The postoperative diagnoses were X.

On X and X, the patient was seen by Dr. X in postoperative follow-up visits. The patient was X. The X exam showed X. The patient was instructed on X.

From X through X, the patient attended X. The treatment X included X. It was documented that the patient had completed X. On X, the patient reported X. X felt X and X. However, X could X. X was recommended to X.

On X and X, the patient was seen by Dr. X for X. The patient was X. The X exam showed X. X was recommended on X.

On X and X, the patient was seen by Dr. X for X. The X exam showed X. On X, the examination revealed X. The X. There was X. X was prescribed.

On X, the patient was seen by X, M.D., for a recheck of X pain. The X pain was X. The pain was located in the X. Associated symptoms included X. Exacerbating factors included X. Relieving factors included X. The patient

only reported X. The X exam showed X. The diagnoses were X. X was continued.

On X, Dr. X documented that the X claimant presented with a chief complaint of "X." However, Dr. X states, "On a scale of X to X, the intensity is described as X" and "X denies X pain. The associated symptom was "X" without further clarification. X was an aggravating factor, likewise without clarification. The exam was demonstrated X was not documented. The claimant complained of only "X" to X. X of the X and X and X. The anticipation was to X.

On, the patient X was interviewed by Dr. X during a telemedicine visit for X pain, but no improvement in X. Obviously, a physical exam was not documented. Based on X was recommended.

Per Utilization Review by X, M.D., dated X, the request for X was denied on the basis of following rationale: "*Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, X is recommended for pain after X. In this case, the patient presented with X pain. X was status X dated X. A request for X was made; however, X were limited to warrant the need for the requested diagnostic as the patient X. Also, the X was X on the X. Moreover, there was X submitted for review. Lastly, the X report performed on X must be submitted for validation and review. Clear X were not identified."*

Per Utilization Review by X, M.D., dated X, the request for X was denied on the basis of following rationale: "*Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. X was not established in the recent office visit as noted by X, denied X. It was also noted that the X. Furthermore, the recent office visit should supply a X request and documented with X. I made multiple attempts to contact the surgeon to garner additional information or X. This was unsuccessful. Therefore, based upon the provided documentation, the request is not currently supported."*

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

The rationale for the denial of the two requests for a X by the two preauthorization consultants appears to have been formulated appropriately.

At X months after X, X. Most patients may expect such X. X are not indicated, as the findings from such are X.

On X, the claimant had X. From practically any medical reasonableness perspective and evidence-based standpoint, there is no medical indication for further investigation with X. It appears that the X was ordered after a telemedicine visit on X that obviously could not include a physical examination; thus, no new clinical findings were used by Dr. X to formulate the rationale for the request since the nearly normal examination on X.

☐ Medically Necessary

X Not Medically Necessary

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES