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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: Board Certified X

REVIEW OUTCOME:

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

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X with a date of injury X. X was X. X stated that X was X. X was on X. It caused X. X was X. X was evaluated by X, DPM on X for follow-up of X. The X and recommended X had been denied. X requested a X to X, as it had X in the X. X it. X reported X. On examination, X was X. X on the X. There was X. On the X, there was X. X of X. The X and X. X on the X. X showed X. X showed X. An MRI of the X. X was X. X and X was X. There was X with X. X was X. X and X were X. X-rays of the X showed X. X changes were X. Treatment to date included X. Per a denial letter dated X, x-rays of the X showed X. An MRI of the X showed X. X was X, but X. There was X and X and X with X. There were X and X. Per a Utilization Review Decision letter dated X, the request for X was denied by X, MD. Rationale: "Per adverse determination letter dated X. Moreover, the guidelines indicated that that patient should have X. Thus, the request is not supported." Per an Adverse Determination letter dated X, the prior denial was upheld by X, DPM. Rationale: "Per evidence-based guidelines, X is indicated in patients with X. In this case, the

patient X. X reported X. X also X. There were X were noted. X had X. X-rays of the X, there was X. An appeal request for X was made. Given the X. Furthermore, objective evidence of X could not be fully established as it was noted that X was recommended to X. Detailed X of a recent, X. In this case under review, there is X. There is X of the medial X. All other criteria for this procedure have been not met. Therefore, X and the procedure is not medically necessary per ODG. The criteria for X and X have been met. However, without X of request, the entire request is non-certified."

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

In review of the clinical findings, the claimant continued to X at the X. The claimant's X did note a X. There was X noted at the X. The claimant reported X. Based on the X, there is X. It is X in this case that the claimant X. There are clear X. Therefore, it is this reviewer's opinion that medical necessity is established in this case and the prior denials are overturned.

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