Applied Independent Review
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A description of the qualifications for each physician or other health care provider who reviewed the decision:

X

Description of the service or services in dispute:

X

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

X

Information Provided to the IRO for Review:

X

Patient Clinical History (Summary)

X is a X who was injured at X on X. The mechanism of injury was described as X. In an office visit note dated X, it was documented that X was X a X and the X and X and now the pain X and X. The diagnosis was X.

Office visit notes by X, MD were documented on X, X, and X. On X, X complained of X. The X was X on the X. X was able to X, X, and X. The pain X. It was X. The pain was described as X, X, X, X and X. X helped it. It was made X. X was not X. On examination, X was X and X was X. X were X. X was X. There was X and X. On X, it was noted that X. X had been denied in spite of meeting ODG. Examination was X from the previous visit. Per the X note, there were no

significant changes in the X since the previous office visit. X was noted to be using X.

An X dated X, identified a X at X, X and also X. There was X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X, under X, as an X was denied by X, MD as not medically necessary. Rationale: “Given the noted X noted on X, X noted in the Official Disability Guidelines, there is support for this X. However, there is X. As such this is not certified.”

Per a utilization review adverse determination letter dated X, the reconsideration request for X was noncertified by X, MD. Rationale: “Per ODG, "Patient criteria for X ... X is not generally recommended. When required for X, a patient should remain alert enough to reasonably converse." In this case, there is no record of X that would X for this procedure. X is not recommended and there is no record of factors that would indicate such X as to require the involvement of an X. Monitored X is not shown to be medically necessary. Furthermore, imaging did not reveal evidence of X. Thus the request is not certified.”

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

Based on the clinical information provided, the request for X, under X, as an X is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X, under X, as an X was denied by X, MD as not medically necessary. Rationale: “Given the noted X, the X noted on X, X noted in the Official Disability Guidelines, there is support for this X. However, there is X to complete is rather X. As such this is not certified.” Per a utilization review adverse determination letter dated X, the reconsideration request for X, as an X was noncertified by X, MD. Rationale: “Per ODG, "Patient criteria for X ... X is not generally recommended. When required for X, X." In this case, there is no record of X. X is not recommended and there is no record of factors that would indicate such X as to require the involvement of an X or X.

Monitored X is not shown to be medically necessary. Furthermore, imaging did not reveal evidence of X. Thus the request is not certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is X documented at the requested level on X. The patient's X notes that X. Therefore, medical necessity is not established in accordance with current evidence based guidelines and the decision is upheld.

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 um knowledgebase 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 Internal 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 Médical **Literature** (Provide a description)

☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)