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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

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was X. X was seen by Dr. X on X for an X, X, X, and X following a X. Dr. X referred to an X report that X. X also referred to X that were X. Dr. X noted that the patient had X previously with X. At the time of the evaluation, the patient was X, X, and X. X documented the patient to be X, though no X was provided. X allegedly had X, X, and X, as well as X. There was X and X. X was said to be X on the X. Dr. X recommended X and X, as well as X and X then X would consider X. X prescribed X. On X, Dr. X performed an X. X, on X, Dr. X repeated that X follow-up visit or documentation of any benefit.

On X, Dr. X followed-up with the patient. X did not document any X and noted that X had been X down to X," which is, in reality, the same X. X, on X, Dr. X performed yet another X, again with no interval follow-up visit or documentation of benefit. Then on X, the patient was seen again by Dr. X. X was the same as all of the previous examinations had been, X was documented and the patient continued to X, X, and X. X noted that requests for further X had been non-certified and that this caused the patient to X when, in fact, X had always been prescribing X to this patient, as well as X and X. No pain level was documented. On X, Dr. X again followed-up with the patient to perform yet another X at the X. X followed-up with the patient X later on X, noting that the X was X than prior such X, yet X also reported X contradicting X own statements. X stated that the patient's X use X, which, in fact, was essentially the same as it always had been with X had been performing. Dr. X also noted that the patient continued to take an X. No pain level was documented and no evidence of X was documented on examination. Dr. X again followed-up with the patient, documenting X and X a X and that X had been X to X. This, in fact, is exactly the same X as X had always been taking through Dr. X. X documented a X with no documentation of which side was tested. It also documented X. X, on X, Dr. X again followed-up with the patient. X again failed to document any pain

level and noted that X was still taking X. X documented X, X, and a X documented. X and a X, Dr. X followed-up with the patient on X. X again failed to document a pain level and stated that X now had X. X continued to take X. No X were noted on examination nor any evidence of X. On X, Dr. X again followed-up with the patient, stating that X was now going to begin X, which is only a X. X incorrectly stated that X was "formerly taking X before that X was, in fact, taking X. No X of X or X was documented nor any pain level. On X, the patient again returned to Dr. X, who finally documented a pain level of X and X continued use of X. No examination was documented nor any evidence of X. On X, Dr. X followed-up with the patient, now documenting that X and X and X. X pain level was X. Despite the X, Dr. X documented that the patient was "X" and had X. X did not document any evidence of X. On X, Dr. X again followed-up with the patient, documenting X with X. X performed only a X, demonstrating a X. X recommended a repeat X. On X, a repeat X demonstrated X. It also demonstrated X. At X was noted with the X. Therefore, every X. X was noted. Dr. X then followed-up with the patient on X after reviewing the X, stating it showed an X. However, X that the X was mostly due to X. X did not perform any X nor did X document any pain level.

On X, Dr. X again followed-up with the patient documenting X from the X. X again stated X had been X, but again did not provide any documentation of the X. X stated that the patient's X which in fact is again, X at all. X incorrectly stated that this was a X which, as well, was X. X recommended that the patient start X. X performed only a X an X and X, but X or X was documented. X request was documented in his progress note. On X, a preauthorization review was performed for Dr. X request of yet another X. The peer reviewer noted that it was "not clear that the injured worker had X following any of the previous X. Non-certification of the request was recommended. Then, on X, Dr. X followed-up with the patient, stating that "at X," which, is not X. In fact, none of Dr. X prior progress notes ever documented X the use of X. X again stated the patient was X, but provided X. X documented an X and X. X again recommended another X. A X reviewer reviewed the request on X, also recommending non-authorization. The physician reviewer noted that X had made three peer-to-peer phone call attempts with Dr. X, leaving a message each time with X office personnel. X cited, as rationale for non-authorization, that there had been no documented evidence of X or X. Dr. X then reevaluated the patient on X. X did not provide any pain level and again stated that X was " X.," when, in fact, that is exactly the X that X had always been X. X allegedly documented X in the X area, as well as X, but X. A X reviewer reviewed the request on X. They noted three peer-to-peer telephone attempts were made to contact Dr. X, each time leaving a "detailed message with a call-back number," but no return phone call was ever made by Dr. X. The reviewer

recommended non-authorization of the X based on the Official Disability Guidelines (ODG) criteria.

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

The ODG guidelines specifically state that X are indicated to treat X. In this case, the patient has X and X at X, but no X and X. The records reviewed since X clearly indicate that the patient has X or X, Dr. X has previously performed. Since none of these X have previously provided objective evidence of either X or X in use and the patient does not meet the ODG X, as discussed above, the request for the X is not medically necessary or appropriate. The prior recommendations for non-authorization are therefore upheld at this time.

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**

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)