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Notice of Independent Review Decision

Review Outcome

Description of the service or services in dispute:
X
Description of the qualifications for each physician or other health care provider who reviewed the decision:

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 who was injured on X. Per the records, X was X, and when X. The diagnosis was X.

On X, X, MD evaluated X for X and X follow-up. X reported pain in the X. X included X and X, X, and X. Associated symptoms included X. X showed X

to X, X to X, X, and the X. X was X. X and X were X. The assessment was X. No X or X was prescribed. X was scheduled for a X.

X dated X showed X, X; mild X; and X. X dated X showed X at the X; and X.

Per a utilization review adverse determination letter dated X, the request for X, X was denied by X, MD. Rationale: “Per evidenced-based guidelines, X are recommended for patients with X and X. In this case, X, X was requested; however, objective clinical findings presented were insufficient to fully meet the criteria of the requested X. There was no clinical evidence to suggest the presence of significant X. In addition, given the patient’s X, guideline indicated that X. Furthermore, detailed objective evidence that the patient had X was not completely established in the medical records submitted to consider the requested X. As the medical necessity of the requested X was not warranted, the requested X is not supported as well.”

Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. 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 evidenced-based guidelines, X are recommended for X. In this case, a request was made for APPEAL X. However, there were no additional medical records submitted with pertinent information that would overturn the previous denial. Prior non-certification is upheld. As the primary request for X was not deemed medically necessary, this precludes the need for X.”

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

The ODG supports X for significant X when a history, X and when there has been a X. The ODG supports the use of a X for more complex procedures. The documentation provided indicates that the patient presented with a X. An examination documented X. An MRI documented a X. The provider recommended a X. Based upon the documentation provided, the requested X would not be supported as medically necessary as there is no documentation of a failure of conservative

treatment. As X is not supported, a X would not be medically necessary. X is also not supported as medically necessary.

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