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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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who was injured on X. X sustained an injury when X and the X. X was diagnosed with X, X, and X. On X, X, MD evaluated X in follow-up for X. X was X and X and X. X presented X. X reported X. On examination, the X / X were X, and X. The assessment was X and X. X of the X were reviewed and showed X and evidence of X. An X was ordered to see if there was anything that could be done to X/X. Treatment to date included X, X, X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Per evidence-based guidelines, X is recommended for X, X. X is recommended X only to X. X use of X for follow-up of X is not recommended. In this case, the patient complained of X. A request for the medical necessity of X was made; however, given the X, clarification is needed if the patient had undergone previous X to the X and must be submitted for validation and review. Moreover,

there are X of X. Besides, repeat X is indicated X. Lastly, there is a lack of evidence that other X such as X were done prior to the request. Exceptional factors were not identified. 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 a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. Rationale: "Per evidence-based guidelines, X is recommended for X. Based on medical report, the patient complained of X with X. Treatment plan included X to see if there was anything that could be done to X and X. There was a previous adverse determination dated X. An appeal request for X for the X was made. However, there were X submitted to validate findings prior to considering the need for this request. Moreover, clinical findings suggestive of X were still not identified. Also, a clarification is needed if the patient had not had X. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified."

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

The ODG recommends X when there is X, and X. The provided documentation indicates the X sustained a X. They required X and X, and X. There has been X with X and X. The injured worker now has significant X. While the two prior reviewers indicated there is a lack of evidence of X, the progress report from X clearly documents that X show X and X. As there is X, X, and X is supported to determine the source of X and X.

Based on available information and ODG recommendation, and X is medically necessary.

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