MEDRX

530 N. Crockett #1770 Granbury, Texas 76048
Ph 972-825-7231 Fax 972-274-9022

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
The reviewer is a Medical Doctor who is board certified in X.

REVIEW OUTCOME:
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
X

The reviewer agrees in part and disagrees in part with the previous adverse determination regarding the medical necessity of: X

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

PATIENT CLINICAL HISTORY [SUMMARY]:
Claimant is a X with a date of injury of X. The mechanism of injury is a X and X. The diagnoses include X, X, X, X, X. Previous treatment has included X, X, X, X. Subjective findings include X. Objective findings include X. The X dated X noted the denial rationale

“However, there was no peer to peer to do a X so all requests are denied.”

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

The appeal request for CT low back IS medically necessary.
Regarding the request for Appeal-X, ODG 2020 notes, X is “recommended for X. X has X for X, due to X and X. X has improved imaging in the X.
Within the documentation provided for review, the claimant has a X. The claimant has exam findings of X and X. Based on the records reviewed, the medical necessity for this treatment has been established.

The X IS medically necessary.
Regarding the request for X, ODG 2020 notes ”Indications for X.

The appeal request for X, follow up IS NOT medically necessary.
Regarding the request for X w/confirm, follow up, ODG 2020 notes X is “Recommended as a X, identify use of X, and X.”
Within the documentation provided for review, there is no clear documentation that the claimant is being X. Based on the records reviewed, the medical necessity for this X has not been established. As such, the request is not medically necessary and is non-certified.

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**

☐ **AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **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)