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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 is a X who was injured on X, when X sustained a X at X and X. (The exact mechanism of injury was not provided). On X, a X of the X was performed at X and interpreted by X, M.D. The indication for the study was X

and X and X. The study was somewhat X due to X and X. X involving the X or X was identified to the X could be evaluated in this setting. (Note: X). On X, an X was performed at X and X and interpreted by Dr. X. The indication for the study was X and X and X. The study revealed: 1) Artifacts from previous X and X to the point where no meaningful comment could be made. X would allow substantially X at this level if clinically appropriate. 2) Above the X, only a X was seen at X, and the rest of the X appeared X. No other X were seen. A X was needed clinically as to appropriate overall follow-up.
On X, the patient was seen by X, X, for a follow-up visit on X, X, X and X and X. X pain level was a X on the day. X presented with X and X. X had X to X per day of X. X was hoping to repeat X in the near future but needed to wait until X sees what Dr. X had planned next. The past medical history was significant for the history of X and X. The past X was significant for X, X, X, X, X and X. The X examination revealed X and X. There was X with a X. The X exam showed X, X. The diagnoses were X, X and a history of X. The plan included X and an annual visit with Dr. X due for X. At the next visit, they would try to X the patient from X of the X so that they could continue to X down as this was a request from X. On X, the patient was seen by X, M.D. X reported the X helped X. X had started to have X in X status post a X and X that occurred on X. X indicated that in the X, X would like to have an X to help X, as X was X. Unfortunately, X was going to X and really wanted them to give X an X before X goes since it helped X so much. It was decided to give X an X in X and X until later in the X if X still wanted to consider having a X. The examination of the X showed X and some X and X and X. The X was administered to the X. The patient X, X. On X, a telephone note by X, X, indicated the patient called requesting an X discussed at the last office visit. X had seen Dr. X on X and had X. Per Dr. X, they could schedule an X, X by Dr. X. The patient stated Dr. X had discussed having X and would get back with them. On X, the patient was seen by Dr. X. X was doing X. X continued to have X. X had an X and sustained a X. X had X. X had continued to X. X also had a X. The X did not seem to help X. X was consistent with a X but X. Because X continued to be X, an X was considered. At this point, it was thought to be probably reasonable to try a X. X stated the X when X and X. The X was much X. The examination of X showed X and X. The patient had a X and the X. X had X. The X of the X were reviewed and showed some X. The diagnosis was X. The recommendation was rather than continuing to give X, try a X. The patient was thought to be a X. On X, a request for pre-

authorization indicated X, M.D., requested the X. On X, a telephone note by X, X, indicated the patient stopped by requesting X. Per Dr. X, it was okay to schedule the X. The patient was also waiting to hear back regarding approval for X with Dr. X. On X, the patient was seen by Dr. X. X stated the X when X had the X, even for an X. X had X, however, that X. It was difficult to sort this out. The X of the X revealed the patient definitely had X. A X that Dr. X ordered did show evidence of X. On the X, as X and X, Dr. X could not reproduce that X. However, as Dr. X, leave it X, and then X, X was X and this did come close to X. X said that once X gets X, but then X and then X, it was like X. The previous files did not show a lot of. X has X from X previous X. The plan was to ask Dr. X to see the patient and for consideration of X to help sort out if X was indeed coming from X. On X, the patient was seen by X for a follow-up on X, X and X and X. X pain level was X on the day. X presented, stating X and X. X had the pain even at X. X also had X. Dr. X suspected that perhaps X had X. X did not really show X, but this was still a X. The workmen's compensation insurance company denied trying a X for the patient; they said that X did not qualify for that X. X was about X from X and X had been approved for X. X pain did originally in X and X. They would try to get X scheduled for X. Also observed was the way X and X had a very X when X. X clearly had some X and X. Some of X issues with X. X stated X had noticed that X was X. X had X and was thought to consider some X. The X revealed an X. There was X and along the X. The patient had X. The X showed X; X. The diagnoses were X and X. The plan included X, a new prescription for X, referral to X, schedule for repeat X and follow-up in X.
On X, the patient was seen at X for X evaluation for the diagnoses of X. On X, and X, the patient attended X. The frequency of the X was X for the duration of X. The treatment X included X, X and X as needed. On X, the patient was seen by X for a follow-up on X, X, X and X. X pain level was X on the day. X reported that X just had X on X. X also started X the next day to X and proper X and X and X. X told X had X. X had a X and X. On exam, the X was X. The patient still started to X. There was X and along the X. X had X to this area. X had X as well, consistent with X. The X showed X. The diagnoses were X, the pain of the X, and X. The plan was to X as X, and prescription for X.

On X, a request for pre-authorization indicated Dr. X requested a X.
On X, the patient was seen by X/Dr. X for a follow-up on X, X, X and X. X

was X. X reported that the X given the last visit X. X was X with the X. X continued to go to X and reported that it was X and X. X had about X. X started to have a X in the X. X would like to repeat the X. X was prescribed X. X was recommended a X. On X, a pre-authorization request indicated that Dr. X requested the X. On X, X, the patient was seen by X for a follow-up on X and X. X was X. X had responded X. X was X and X. Some of X symptoms sounded more X, actually as X. X did respond X. X reported some pain in X. X also had X but did not show to be significant in regard to X per Dr. X. X did sustain a recent X. A similar situation had happened X. The patient was prescribed X. The plan was to repeat the X and X. X was recommended to try X. X was X.

On X, a pre-authorization request indicated that Dr. X requested the X. On X, a pre-authorization request indicated that Dr. X requested the X. On X, the patient was seen by Dr. X for a follow-up on X, X, X and X. X was X. X presented for a X. The assessment was X and X. The patient was administered a X. X was refilled. X was recommended X. On X, a pre-authorization request indicated that Dr. X requested the X. On X, the patient was seen by X for a follow-up. X continued to X. The X of the X was reviewed. Reportedly, X did not have any X. X had X. X had X and X. X was X and did improve X. X had X in the past, which were X. The last X was X. X pain was X. There was also X. X was X. X of the X showed X and X. The patient was prescribed X and X. X was recommended X. On X, a pre-authorization request indicated that Dr. X requested the X. On X, the patient was seen by X for a follow-up. X continued to have X. There was a X, but it was also suspected that X had X. X continued to X and X. X tried to continue with the X but clearly had an X. X would like to repeat the X. On exam, there was X and also some X. The X had X and X. The plan was to repeat the X. X was continued. On X, the patient was seen by X, NP, for X. X also had some pain in the X. The pain was X, X, X and X. X complained of X that seemed to X. On exam, the X had X. The X had X, X and also X. X was noted with X. X was X. X of the X showed X. There was evidence of a X that was X; when X, the X showed X. X was well X. The diagnosis was X. The patient was recommended X. On X, and X, a pre-authorization request indicated that Dr. X requested a X. On X, the patient was seen by X for a follow-up. X reported that overall, X X after the X. This was the X had felt in about X. X was X. X wanted to return to the X and X. X only had X. The plan was to perform a X and X. On X, a pre-authorization request indicated

that Dr. X requested a X. On X, and X, the patient was seen by X for a follow-up. X reported that X continued to X from the recent X and from the X. X continued to X, X. X continued to go to the X. X did have a X, but no other significant X was noted. The patient was continued on X. X was X. The plan was to continue X. X opined that the patient was eligible for X. On X, a pre-authorization request indicated that Dr. X requested a X. On X, and X, the patient was seen by Dr. X for a follow-up. X reported that X current pain was X, X, X and X. X had X on the X. X was concerned that X had been having some X. X was due to have an X and a X. X had a X to X and X had X from that. X had X on X, but X and X. X did not see X with the X. The plan was to perform a X. X and X were refilled. On X, and X, a pre-authorization request indicated that Dr. X requested a X. On X, and X, the patient was seen by X for a follow-up. X reported that X and X. X reported X at the X. X did have some X at times that seemed to X. X continued to X and X. X and X were refilled. The plan was to X. The patient was recommended to X, X. Another X was requested. On X, a pre-authorization request indicated that Dr. X requested a X. On X, a telephonic note from X indicated that the patient called requesting a X and X. Per Dr. X, it was okay to schedule both if Worker's Compensation approved. On X, the patient was seen by X for a X. X reported X since the last appointment. X had X. The pain X. X was X. X was doing X. X continued to have X when X. The patient was recommended to X and X. X and X were X. On X, a pre-authorization request indicated that Dr. X requested the X. On X, the patient was seen by X for a follow-up. X was X. X was X. X reported X. X was starting to have a recurrence of X and X as well as X. X would like to have X and note that the X was also X during that procedure on X. The plan was to get an approved X. X and X were X.

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On X, a pre-authorization request indicated that Dr. X requested a X. On X, X history was documented. On X, the patient was seen by X for a follow-up. X was X. X stated that X. X also had X, which often was X. X would like to X. The plan was to perform X and X and X. X was refilled. On X, a pre-authorization request indicated that Dr. X requested a X. On X, the patient was seen by X for a follow-up. X reported that X was X. X continued to have X, a X was performed at the same time, but this was missed. The patient was X in the X. X was X. The plan was to request another X.

On X, order note by X indicated that X was ordered. On X, X from X was X for

X. On X, a pre-authorization request indicated that Dr. X requested an X. On X, the patient was seen by X for a follow-up on X. X reported X. Approximately, the X was where X experienced X. The X to just above the X. The X were new. X also had X and X and X. X typically was undergoing a X. The patient was recommended to get a X. The plan was to X. X was X.
On X, the X report documented from X was X. On X, an X was performed at X and X and interpreted by X, M.D. The study revealed: X. On X, correspondence from X, indicated that the claim for the patient was submitted on X, and the definitive decision on the claim was not yet received. On X, the patient was seen by Dr. X for a follow-up on X. X was X. X reported X since the last visit. The X of X was reviewed. The plan was to request X. On X, a pre-authorization request indicated that Dr. X requested X. On X, the patient was seen by X for a follow-up. X reported that overall, X and X was X. X started to have some X and X. X did not have a X and X since X. X did get X and X. There was a X, but X was not eligible for a repeat for at X. The plan was to schedule X and X at the same time as an outpatient. X was X.
On X, a pre-authorization request indicated that Dr. X requested X and X. On X, the patient was seen by X for a follow-up on X. X would like to discuss another X. X had X and X, X. X was X. X reported that X was much X. X was having some X. X would have to X from X. The plan was to schedule X. X was refilled. On X, a pre-authorization request indicated that Dr. X requested a X. On X, a telephonic note from X indicated that the patient received X. Per Dr. X, the patient knew that these X could be X. On X, the patient was seen by X for a follow-up on X. X pain was X with the current X. Reportedly, the X last performed was X. The plan was to perform X. X and X were X. On X, the patient was seen by X for a follow-up X. X would like a X in the X. X did not think X was X. X was X. X reported that X and X. The effects of X had started to X. X would also like to X. On exam, there was a pain to X. The X had pain with X. The plan was to X, X and X. X and X were X. On X, a pre-authorization request indicated that Dr. X requested X. On X, a telephonic note from X indicated that the patient X, with X. It was recommended that if the patient continued to have X, it was okay to schedule X and X.

Per Utilization Review dated X, by X, M.D., the requested medical treatment of X and X between X, and X, did not meet established criteria for medical necessity based on physician review of the information submitted. Rationale:

"According to the submitted documentation, the patient was injured after a X. The patient was diagnosed with X, X, X. The patient's current X was undisclosed. Prior treatment included X, X. According to the chart notes submitted by X, X, on X, the patient reported X and X. X had a pain level of X. The review of the system was remarkable for X. On examination, the patient had X. X had X. X had pain in the X, X. Per the prescription dated X, the treatment plan included X. Regarding the request for a X, the Official Disability Guidelines state that an X is not recommended. X has been associated with X and X. The prior request was certified in review X. After reviewing the submitted documentation, the patient presents with X. The patient was diagnosed with X. There is no rationale provided for proceeding with an X despite the guideline recommendations. Therefore, the request for X is non-certified. Regarding the request for a X, the Official Disability Guidelines recommend a X. A X can be considered at X following the first, with documentation of a minimum of X. X is the X. For X, X is safe and effective, with a X usually providing X. After reviewing the submitted documentation, the patient still presents with X. The patient was diagnosed with X. A prior request was certified in review X on X. However, there is no indication that the patient had pain X; therefore, the request for X is not warranted. Based on this, the request for X is non-certified." Per Utilization Review dated X, by X, M.D., the request for reconsideration of a previous non-certification was reviewed. Reportedly, the requested medical treatment of X and X between X, and X, did not meet established criteria for medical necessity based on physician review of the information submitted. The original determination was therefore upheld. Rationale: *"The request for X and one X was non-certified by Dr. X in review X on X. The physician reviewer noted that there was no rationale provided for X despite guideline recommendations. Also, there was no indication that the patient had X. Additional clinical information was subsequently made available for review. Remarkably, a X, chart note indicated that the patient had X, with respect to the X. However, it was also noted that the patient was still having X. Upon review of the submitted documentation, the patient sustained an X. The patient was diagnosed with X. As a result of the Injuries, the patient was X. The patient's current work status and modified work history were undisclosed. Attempted treatment included X, a X, X, and a X. The X revealed X and no evidence of X. The provider is appealing the previous determination at this time. Regarding the request for a X, the Official Disability Guidelines state*

that an X is not recommended, X has been associated with X and X. The requested X is not supported at this time. A review of the submitted clinical documentation did not reveal extenuating circumstances that would warrant bypassing guideline recommendations, which do not recommend a X. X., the request for X is non-certified. Regarding the request for a X, the Official Disability Guidelines recommend a X. A X can be considered at X. X is the X. For X, X and effective, with a X usually providing X. The requested X is not supported at this time. A review of the available and submitted medical records did not reveal any indication of the patient having at least X from the X. X, the request X is non-certified".

On X, the patient was seen by Dr. X for a follow-up on X and X. X was X. X reported no recent changes since the last visit. X reported at X in X. On exam, the X and X. There was X over the X. The assessment was X, X and X. A X was requested. X and X were X. Dr. X would request permission to appeal the denial for X.

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

In patients with X who are referred for X to X, the indication for X should be X. Case series and retrospective reviews have shown that some patients who develop X or X. Clinicians should consider obtaining a X before each subsequent X to evaluate for X and any X. The ODG does not recommend X. The patient has had X with return of X. Prior to consideration of a X, X are recommended and X if indicated. Thus the requested, X is not certified as medically necessary at this time. Regarding the request for a X, the Official Disability Guidelines recommend a X. A X can be considered at X, with documentation of a X. It is documented that the patient received X. Thus, the requested X is certified as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT**

GUIDELINES