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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:

The physician reviewer is Board Certified in 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. X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records provided for review, this patient is status X in X with continuing complaints of X. On X, X studies with Dr. X, demonstrating X and X and X. A MRI scan was performed on X, demonstrating the prior X with X, X, and X at X. At X, there was also X. X or X was noted. On X, Dr. X performed X. X, X followed-up with the patient on X, noting X history of procedures, beginning with the X in X. X complained of X pain X with X. X reviewed the X study of X and the X study by Dr. X on X. Dr. X noted that the patient had undergone X and X on X followed by X and X on X, also with X. X later, the patient underwent X, again with X. X documented X with no change on X. X was X. X was, for the most part, X, except for X and X. X was X and X and X were X. Dr. X noted the patient's X and X. X recommended X followed by X and X.

On X, Dr. X performed X. X followed-up with the patient approximately X later on X, reporting X of X, as well as the same X in pain following the most X, the same as every previous other kind of X performed. X now demonstrated X and X with X. X now was completely X and X was X. X was X and X. Dr. X recommended X and X. An initial review by a physician advisor on X recommended non-authorization of the requested X. The reviewer cited the Official Disability Guidelines (ODG) criteria and the patient's continuing complaints of X and X. A second physician reviewer reviewed the file and appeal request on X, also recommending non-authorization of the requested procedure, again citing the ODG criteria and the patient's continuing complaints of X and X, as well as the X and X. The reviewer also noted that the patient had previously undergone X followed by X and the lack of support in the ODG criteria for repeating that procedure.

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

This patient has documented continuing X and X, as well as physical examination findings of X and X evidence of X. According to the ODG, this patient does not meet the ODG criteria for performing X, as the criteria include the X and symptoms. Moreover, this patient has already undergone X and X with, at X of insufficiency duration to justify repeating either of those procedures. Therefore, according to the ODG guidelines, this patient does not meet the criteria for X and X and X. Moreover, the imaging studies clearly demonstrate nothing more than X at the X, which is insufficient to X. Additionally, there is no X of X or X to X any X. Finally, the fact that every one of the procedures performed by the requesting physician seems to provide almost exactly the same degree of relief, whether that treatment is X, X, or X, indicates that the X, X, are not likely either the X or X and, therefore, do not require further attention. The requested X and X and X is not medically necessary, appropriate, or in accordance with the ODG and therefore, the recommendations of the prior two physician advisors to deny authorization of the procedure are 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)