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An Independent Review Organization
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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 sustained an injury on X, when X at X and X in the X and X. X and X and X. X was diagnosed with X, X, X, pain in X and X, pain in X and X, other X, and X. X was evaluated by X, X on X. X reported X and X. X pain was X and behind X. Examination findings were X. Assessment included pain in X and X; X. The treatment plan was X. X, X, and X were continued. X was evaluated on X by X, FNPC for a follow-up visit for X. Pain was X. X reported X status X. X worked as an X and X and with the X which had X. It was X due to X and X. X had tried X, X, and X without X. General examination was noted as X. X was X. The treatment plan was X. X was advised to continue X, X, and X. On X, X was seen by X, X for continued X rated X. Examination findings were X. X was diagnosed with pain in X and X, pain X and X, X, and X. The treatment plan was X. X of the X dated X was X. X dated X, was X, X, X, X and X. Treatment to date included X, X to include X and X in each X

and X in X, X and X. On X Utilization review denied X. Peer discussion was performed with Dr. X. It was noted that X had X status X. X responded well to a X. While the requested X was discussed as being a X, evidence-based ODG guidelines did not support this procedure as it was considered to be X at the time. The determination was not agreed upon. A Letter of X by X, MD has been submitted for this review requesting X for X and X. The patient has X. On average, X. X has been X from X and X, X and X including: X and X. X pain X with X, X, X; and X. X had X relief to the diagnostic X. The patient has completed a X. The provider recommended a X. Peer review was completed on X by X, DO and the request for an X was non-certified. Per peer rationale "Based on the clinical information provided, the request for X is not recommended as medically necessary. The Official Disability Guidelines note that X is not recommended, including X and X including X, X, and X. While it has been suggested that X may X, there are still X in knowledge requiring further research. Data on these X has been X, X, and X. There is X provided to support the request X recommendations. Therefore, medical necessity is not established in accordance with current evidence based guidelines." Per a Letter of Preservice Authorization Appeal, it was noted that the provider had submitted an appeal letter dated X appealing the recent non-certification of X. For over X, the patient has suffered from X. On average X reports an X. X has attempted to X, X but pain and X. X has also failed or has not sustained long term benefit from the following X: X; X; X and X. Due to ongoing and X, the physician and patient have requested approval for implant of the X. X, MD performed a peer review on X and upheld the denial for an X. X, "According to ODG, X for pain is not recommended, including X and device X including X, X, and X. Peer review on X noncertified the request for an X as ODG does not recommend the X. It remains relevant while it has been suggested that X may X or be a X for X, there are still X in knowledge requiring further research. There is insufficient evidence to support the X and X for any indication. The previous determination remains supported. Therefore, my recommendation is to NON-CERTIFY the APPEAL request for X.

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

X agree with the previous denial. There is a lack of support in the medical literature as well as evidence-based guidelines for X. According to ODG, X for X is

not recommended, including X and X including X, X, and X. The safety and efficacy has not been well established.

Based on the records reviewed, the request for X is not medically necessary and the previous denials are upheld.

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