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Notice of Independent Review Decision

Review Outcome

Description of the service or services in dispute:
X

Description of the qualifications for each physician or other health care provider who reviewed the decision:
X

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 when X. X was diagnosed with X.

On X, X underwent a X on X at X by X, PT. The goal of the X was to X. On examination, X showed X and X. The X and X had X. On special testing, X and X were X. X of the X was X. X qualified as X under X. X used acceptable X and was able to X. X presented a X throughout X evaluation.

X ongoing complaint was X. X stated X alleviated X. X reported X diagnoses X. X would benefit from further X including X to safely return to X.

Treatment to date included X and X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “According to the records, the claimant has only had X to date with X. X advised X that at the time the request for X is premature and does not have medical necessity. As such, recommendation is for non-certification.”

Per a utilization review adverse determination letter dated X, X, MD denied the request for X with the following rationale: “Based on the clinical information provided, the Reconsideration for X is not recommended as medically necessary. The initial request was non-certified noting that, “According to the records, the claimant has only had X to date with X remaining. X advised X that at the time the request for X is premature and does not have medical necessity. As such, recommendation is for non-certification.” There is insufficient information to support a change in determination, and the previous non-certification is upheld. There is no comprehensive assessment of X completed to date or the patient’s response thereto submitted for review. There are no X records submitted for review with documentation of X and patient response. Additionally, ODG notes that no more than X should be utilized per X and ODG would not typically support utilization of X. Therefore, medical necessity is not estimated in accordance with current evidence based guidelines.”

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG recommends up to X following X. The ODG does not recommend X following X. The provided documentation indicates the X status post X. The X was reportedly X with the provided medical records documenting completion of X. As the provided documentation indicates

the X followed by reevaluation documenting X, additional X is not supported. As such, recommendation is to uphold the prior denials for X. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐
- ☐ DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)