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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 Physician

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 alleges an injury on X, while at X. X was getting ready to X.

On X, X was performed at X and interpreted by X, M.D. The study revealed: 1) X. 2). X. 3) X. 4) X. 5) X.

On X, the patient was seen by X, M.D., for X injury on X. X was about to X. X had X at that time but had X the X. X felt X by X. Examination of the X revealed X. X was X and X. The assessment was X. Awaiting medical records and X. (Largely illegible handwritten records).

On X, the patient was seen in a follow-up by Dr. X for X. Recommended follow-up on X. (Largely illegible handwritten records).

On X, the patient was evaluated by X, M.D., for X injury sustained at X on X. X was trying to X. X also reported X. X noted that if X and X, X experienced X. X localized X to the X. X had been X over time. X noted X. X had X. X felt as if something was "X." X had an X. Examination of the X revealed X. With X, X was noted in the X consistent with X. At the same time, further X did cause X. X was noted. X was noted along the X. X was X for X. This was X. This caused the patient's X. X of the X were X. X of the X was reviewed. The diagnoses were X. The treatment plan included X. X plan was discussed in detail, which would include X. Recommended to continue with X.

On X, a Prior-Authorization Request Form was completed by Dr. X. The service requested was X.

Per an Initial Adverse Determination by X, M.D., the request for X was non-certified. Rationale: "*Based on the clinical Information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, X is indicated in patients with pertinent subjective complaints and objective clinical findings corroborated by X after the X. X and more X with X can undergo X without X. In this case, the patient is X and the injury is X stating X. X an X found X in the X. There is no evidence of adequate X for X of this condition. A request for X was made. The guidelines stated that X also suggests X outcomes. The patient has a X and given the lack of X with X, guideline support a trial of X which is not identified in the records*."

On X, the patient was seen in a follow-up by Dr. X for ongoing X complaints.

Authorization for X was denied based on the reviewer stating that no evidence of X. The reviewer also mentioned X was a X to X. X continued to have X and noted that if X and X, X noted X. X localized X to the X. X also noted having X. X had been X. X noted X. X had not been able to X. Again, X felt as if something was "X." Examination of the X revealed X. With X, X was noted in the X consistent with X. X was noted with the X. At the same time, further X did cause X. X was noted. Again, X was noted along the X. X was X for X. This was X. This caused the patient's X. X of the X was reviewed. The diagnoses were X. The plan was to continued X and submit an appeal for the X. If again the appeal was denied than the patient would be sent for an Independent Review Organization (IRO) determination.

On X, a Medical Peer Review was completed by X, M.D. (The medical document was incomplete).

Per a Utilization Review dated X, by X, D.O., the prospective request for X was non certified. Rationale: "*Per evidenced-based guidelines, X is indicated in patients with pertinent subjective complaints and objective clinical findings corroborated by X studies after the X. In this case, the patient continued to have X symptoms in regard to X. X did a X. Again, to suggest a X would afford X was not a judicious utilization of resources. This will only X. A X with X which was symptomatic and had X symptoms will X until X has undergone X. A X will lead to X and is not a treatment that would be considered standard of care for X with X. In regard to the claim of X, X was a X. X had a X. With X and X, a X was noted. X showed X. This was also evidenced by X examination and also X symptoms. An appeal request for X was made. However, it was noted in the most recent medicals that the patient's X was X and there was still no mention in the most recent plan that X was made prior to considering the request. The non-cert is upheld*." Primary Reason(s) for Determination: "*Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request is non-certified. It was noted in the most recent medicals that the patient's X was X and there was still no mention in the most recent plan that X was made prior to considering the request*." Criteria used in Analysis(Guidelines/ Screening Criteria) Official Disability Guidelines X for X and X Conditions (Last review/update date: X).

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE

CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The two adverse determinations (non-certifications) were formulated inaccurately, per ODG criteria and X common sense. The request for X by Dr. X was very thoroughly documented, very well explained and supported, and stands as an example of how to "X" when submitting a request for X.

The adverse determination should be OVERTURNED. The requested X IS MEDICALLY NECESSARY.

X, M.D., a X physician, formulated X adverse determination opinion in error. Dr. X correctly noted that, "per evidence-based guidelines, X is indicated in patient with pertinent subjective complaints and objective physical exam findings corroborated by X studies after X." X did not, however, admit that Dr. X had, in fact, documented:

- subjective symptoms of "X" with X;
- examination findings of X;
- X evidence of X; and
- X had been completed (and X, X the symptoms).

This could not be a more cut-and-dried case in support of the ODG-approved indications Dr. X listed in X opinion analysis:

1. Conservative care: X is not required in cases with X, as in this case. Even if no X symptoms were documented, X was attempted and failed due to X symptoms, classic for X.
2. Subjective clinical findings: X, AND
3. X symptoms were documented, PLUS X.
4. X evidence of X was documented and consistent with the symptoms in this X without evidence of any other X finding.

X (X) has absolutely nothing to do with the determination of medical necessity, per the listed ODG criteria.

The X is a CLASSIC manner in which to X, common knowledge among X.

X, D.O., a X physician, acknowledged awareness of the four ODG criteria

(those acknowledged by Dr. X, as listed above). In the last paragraph of X of X report, Dr. X confirms every one of the four criteria had been met. Despite this, Dr. X based X adverse determination on “recent medicals that the patient’s X was X and there was still no mention in the most recent plan that X was made prior to considering the request.”

Again, X (X) has absolutely nothing to do with the determination of medical necessity, per the listed ODG criteria.

Therefore, both X and X are medically necessary.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES