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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 was injured on X when X. The diagnosis was X. On X, X was seen by X, PA-C / X, MD for X and follow-up for work-related injury. X had X with X for X and would like to X. X had undergone X for X by Dr. X, did X, and was doing a X (X) at the time. X had X and was X and X if X was on X. X at X. The X was X and X, X with X and X. It was X by X. X reported X in X and X with X. X had X since the X (X) and only used it X. X had run out of X and wanted to resume it. X reported X was X when X was X and X but had X and with X. X continued X for X as the X was X to X. X reported X had ongoing X when X was X and X, so X. X reported X at the end of a X. X was interested in X. X reviewed on X revealed X was on X by Dr. X. The X was X at the time. On examination, X was X. X was X, X, X, X. X was X. On examination of the X, there was X. X wore a X, had X and X. X had X to the X and X. X had X and

X. The X was X at X and was X. X of the X had X since the prior examination. X had X and X and X. The diagnosis was X. X reported X with X for X and would like to X. X was discussed and X declined at the time. X was X. X was recommended to X and X to allow X to X and X. X reported that work was X as X had X and X with being on X. X and X was encouraged. Referral to X would be considered. Treatment to date included X. Per a utilization review adverse determination letter by X, MD, dated X, the request for X was non-certified. The rationale was as follows, "Per the ODG by X, X are not recommended based on a lack of quality studies. Since the X has been widely performed, despite lack of evidence of effectiveness, other more proven treatment strategies like X and X should be X. The claimant reported X. The request is for X. Evidence-based guidelines do not support this X. No exceptional factors were noted. Hence, this request is not medically necessary. Recommend non-certification." Per a reconsideration review adverse determination letter dated X, X, MD upheld the original noncertification for X. Rationale: "Regarding the requested X, the Official Disability Guidelines do not recommend X for X. The guidelines specifically indicate they are not recommended based on a X. If utilized anyway, there should be evidence that a program of X or X is incorporated with the X, and X use of a X is only recommended in cases that have had a X to a X. The submitted documentation does not detail the above. The documentation indicated the claimant underwent a prior X with the most recent being in X. However, the guidelines do not recommend this treatment based on the X the X, therefore, given the lack of recommendation in addition to a lack of documentation supporting there has been a X fulfilling specific criteria, the requested X is not medically necessary and is non-certified."

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

The medical records were reviewed. The claimant presents with classic signs and symptoms of X of the X. The X evaluation noted X. X had X and X and X. X had X to the X and X. X had X and X. The X was X at X and was X. X of the X had X since the prior examination. Previous X provided a X in X for X.

After considering the request, it is my medical opinion the X is supported as medically necessary.

**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