MEDRX

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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 reviewer is a Medical Doctor who is board certified in X.

REVIEW OUTCOME

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X who was involved in X on X. The injury was described as X. X was X, however/reportedly, no X was X and no X

were X. X has had X for X. X was described as X. The patient also X of X at X.

On X the patient was evaluated by X medical provider. The patient complained of X at X, with X of the X. X admits to X. X has reportedly X. The patient also complained of X at X. There were X. The patient was diagnosed with X. The recommendation was for X.

A X was performed on X. The patient noted X. X was X. X testing of the X was X. X and X was X in the X. X, X and X were X. X was provided.

An MRI of X dated X revealed X.

X testing of the X dated X revealed X.

On X the patient underwent X for the diagnoses X.

On X the patient was evaluated for X and X at X. The examination noted X. X testing of X was X. X testing and X testing was X. X, X and X were X. The patient was diagnosed with X. The report indicated that the patient X. X has not X.

On X the patient underwent an examination. The patient reports X and X of X. There was no X of X or X and no X. There was no X in X. The X of X was X. X in X was X. X and X was X. X was X. X was X. X and X were X. The patient was diagnosed with X. The recommendation was for X. The patient "is noted to have X. X has had X it was X but X. The X were X. X is X and in the X. These are consistent with X. So far X has had no X because apparently there has been some delay in the approval." The recommendation was for X.

A peer review dated X resulted in X. The rationale for denial was X. Additionally, the treating provider recommends X. However, specific objective functional benefit and X as a result of the X is not documented. Furthermore, there is no documentation of X.

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

The prospective request for X is not medically necessary.

ODG guidelines, X states that X are X. X are the only recommended approach; X are not recommended. This treatment should be administered in conjunction with X. X are not recommended as a treatment for X.

This patient presents with X. The patient presented with X. The reevaluations noted similar subjective complaints on each date of evaluation. The patient underwent X. The X evaluation was quite similar to the X evaluation. The provider stated that the patient X. X has not X. However, submitted documentation does not evidence specific objective functional benefit and X. ODG guidelines support a conditional recommendation for X. There was no clinical objective exam X. The prior X documented X.

ODG guidelines indicate that X. The submitted documentation did not provide detailed evidence of X. In addition, X are not recommended." Overall, there is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines at this time. Therefore, this request for X is not 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**

☐ **AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **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)**