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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:
Board Certified 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 sustained a work-related injury on X. The mechanism of injury was described as X. The diagnosis was X. X was noted to have X.

On X, X, MD evaluated X for the chief complaint of X. The pain X. MRI of X was X for X. X was X. The pain level was X. X was X at X. The pain was described as X. X helped. It was noted that X had been denied in spite of meeting ODG. There were no significant changes in the X since the previous office visit. Examination on X showed X. The plan was to appeal the denial.

An MRI of X dated X showed that at X, there was X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the prospective request for X was noncertified by X, MD. Rationale: "Per evidence-based guidelines X are recommended on a case-by-case basis as a X for patients with X. In this case, the patient complained of X. X pain level was X. X pain level was X. X was described as X. On the X examination, there was X. A request was made for X. Given the presented subjective and objective clinical findings, the request may be supported, however, there was no actual X studies. Also, there was no clear objective evidence that the patient had X. Moreover, there was no clear objective documentation that this procedure is X. Furthermore, there is a limited research to support X, and all of the studies have methodological limitations. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request is non-certified. We need more records regarding the patient's history to better understand the need for X, as stated. X history is unclear."

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Notice of Independent Review Decision

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "Per evidence-based guidelines, X Is proposed for use as X in patients with X where the diagnosis remains uncertain after standard evaluation. This procedure is primarily performed X and is not X. In this case, the patient complained of X. The X, X. The X was X. It was described as X. X was X. The X, X. There was a previous non-certification of the request for X. The MRI of the X dated X showed that X. An appeal request for X was made; however, there was no indication that the patient had X. Moreover, clarification is needed for the requested X as there was no X for X. Also, there was an MRI report submitted that was unequivocal. Clarification is needed as to how the request might affect the patient's clinical outcome. Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced above, this request is non-certified. There was no indication that the patient had X. Moreover, clarification is needed for the requested X, as there was X for X. Also, there was an MRI report submitted that was unequivocal."

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

There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted X MRI notes that X. Peer review dated X indicates the patient's diagnosis is X which is typically treated with X of X. The patient's physical examination fails to document X. Therefore, medical necessity is not established in accordance with current evidence based guidelines for the requested X.

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)