Applied Independent Review
An Independent Review Organization
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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

X

Description of the service or services in dispute:

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 was X and X, X. The current diagnosis was X, X, X / X, X, and X.

On X, X, MD evaluated X who presented with X. Symptoms included X. The X was described as X and X and X. X stated the symptoms were X and X. They were X at the X, X, and X. X presented to X for the X. X noticed X and X. Examination of the X noted X and X. X was X. X was X and X, and X. X was X, X, and X. X was X. Dr. X noted that at the time, X continued to have X, X, and the X. In addition, X had X and had X including X, X, and a X. X felt X would likely require X to X. X may return to work with X.

An MRI of the X dated X revealed X.

Treatment to date included X, X, X, and X.

Per a utilization review adverse determination letter dated X, the request for X, and X was denied by X, MD. Rationale: “Based on the submitted documentation, the treatment request is not warranted at this time as other elements of the treatment plan are not supported. The claimant was X being supported by the guidelines to warrant X. There was X on the X. The X showed X of the X. Moreover, there was X on the X of the X or X. Additionally, X was recommended for claimant's X. As such, X, and X were not supported. The claimant was able to meet X and X. However, it cannot be authorized, as other elements of the treatment plan are not necessary. Therefore, the request for X is non-certified.”

Per a reconsideration review adverse determination letter dated X, X, MD denied the appeal request for X. Rationale: “The Official Disability Guidelines state that X allows X to be performed through X, X. X and signs to X. Criteria includes conservative care; X, X, X of X, X, X, or X; X. X requires a X and X. X, is X have been reported. X is supported for X, there is reported X and X. X is recommended X are consistent with a X, after X. It appears that the previous non-certification was warranted. The claimant still does not meet the requirement for X, X remain supported. As this is an all or nothing jurisdiction, the prospective request for X is non-certified.”

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

The ODG supports X for X when there are X and X, and X. The ODG conditionally recommends a X and when there is pain and X, and X. The ODG conditionally recommends a X when combined with other X. The ODG conditionally recommends X when there is evidence of an X and/or X. In this case, the X. There is X and mechanical symptoms despite X, and X. The examination indicates that there is X, a X, X. The MRI is consistent with a X; however, there was X. While proceeding with the X and X would be supported, there remains insufficient imaging findings to support the request for a X the prior denial. However, further X for the X would not be expected to provide X. In consideration of the ODG and

available information, the X and X is medically necessary; however, X is not medically necessary. The recommendation is for partial certification.

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

The X and X is medically necessary and overturned.
The X, and X is not medically necessary and upheld.

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 um knowledgebase 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 Internal 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 ManualPeer Reviewed

☐ Nationally Accepted Médical **Literature** (Provide a description)

☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)