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Notice of Independent Review Decision
Amended Letter

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 with a date of injury of X. The X of injury was X. The diagnosis was X.

A progress note dated X by X, MD included a X and X. The reported mechanism of injury was X. X include X. Current symptoms were not rated on a X. A X revealed X at the X and X in the X. X was X. There was also X noted to support a diagnosis of X. X was X.

Per a Clinical Note dated X, Dr. X evaluated X for X and X and X, X. The X was X and X from X. The pain was located in the X, X, and X. X had

received X in the X. X reported on the X, X had X after getting the X. X reported X for the X and X on the X for only X. X stated that X of the reported X, X was already X to X. On examination, there was an X. Dr. X commented that X had X and X, X where X started after X.

X dated X showed evidence of X.

Previous treatment has included X. There was also X.

On X, the request for X, X was non-certified: Rationale: "This employee has complaints of X and X. However, there are X to support X other than X. There is X, X, X, X, or X. Additionally, there has been X with any X which may be X and X. Accordingly, this request for an X is not medically necessary.

On X, the reconsideration request for X was non-authorized. Rationale: "The Official Disability Guidelines only supports X for individuals with X who have X. X of this injured employee dated X only reveals an X. There is no X performed X, X, X, or X. X was noted. Additionally, X is only X recommended on this date and there is no X. X findings and without exhausting conservative care, this request for a X is not medically necessary."

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

The claimant had been followed for X. The X were consistent with evidence of X. The claimant's X were X; however, without any indication of X, X, or X. Additionally, the records did not detail failure of X that would support proceeding X as requested. Therefore, it is this reviewer's opinion that medical necessity for the request is not established.

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)