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Notice of Independent Review Decision

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 was injured on X. X was X as part of X when a x onto X. The diagnoses were X.

On X, X was evaluated by X, DO for X. X continued to X in a X. X would have X all the way to the X and the X. On examination, X was in X and X. There was a X, X or X. X and X were X. Dr. X believed X would benefit from X.

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

On X, a peer review was performed by X, MD who opined that the request for X for the X is not medically necessary. Rationale: “The request for X, a X, is not medically necessary, As noted in ODG's X Chapter X, such X are deemed not recommended. The attending provider failed to X a X or X in X the X in question in the X context present here in the X ODG position on the same. Therefore, the request is not medically necessary.”

On X, the peer review by X, MD indicated that the request for X for the X was not medically necessary. Rationale: “Within the documentation available for review, there is documentation of an appeal request for a X. Additionally, there is documentation of X to X. Furthermore, there is documentation that treatment has included X, X, X, and X. Moreover, there is documentation of a X dated X, which identifies that a request for a X was non-certified because per ODG, these devices are not deemed recommended, and the attending provider X a X or X in favor of the decision to X in question. An appeal dated X, identifies the request is for the X and X, X, or X. It also identifies that it is an X in treating X. However, guidelines do not support X and the denial's concern regarding a lack of documentation of a rationale for treatment outside of guideline recommendations has not been addressed. Therefore, X is not medically necessary.”

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

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that the requested device is not generally recommended. While it has been suggested that X may X or be a X for pain treatment, there are still gaps in knowledge requiring further research. Available systems are noted to include the requested X. When treatment is outside the guidelines, exceptional factors should be noted. There are no exceptional factors of X documented. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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)