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:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
This X sustained an injury on X. Review of the records reveal X is being treated for X and X.

X note dated X has X for X. X is status X. X notes X. Pain is rated X out of X. X has X of X. X is X, X, and X. Treatment plan is to continue X. X note dated X has X as X. X reports continued pain with X. Pain is X out of X. X of X is X, X, and X. Treatment plan is to continue X. Progress report dated X has X having undergone a X on X and has had X and X. X has been going to X. X still X. X cannot X. X is having a X and X. Exam of the X. X can only X to about X and X before X has X and X. This is X; therefore, X. Treatment plan includes an X and X. Letter dated X has X being status X and is still X and X. X was seen on X and noted X. There have not been X and continued X. The current X and X. It is medically necessary for this patient to receive the X of treatment in X to help X. Previous utilization review dated X non-certified the request for the X. Rationale states the progress note dated X does not indicate if there is X and X. X exam is also X, and this request is also not stated to be specifically for the X. No additional progress notes are provided. Due to insufficient clinical data and without additional information regarding X, this request is not certified.

Previous utilization review dated X non-certified the request for the X. Rationale states it is unclear if there is still X or not. As such, this request is not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
As per ODG, “Not recommended for X. While this X cannot yet be broadly recommended, it is an alternative option in X with X alone has been clearly unsuccessful in X, otherwise needing X and/or X. In this situation, it could be considered

on a case-by-case basis for an X in X, as an alternative to more X. If the patient subsequently experiences well documented X, then additional approval for a X could also be reasonably considered."

In this case, this X sustained an injury on X and is status X. X presented with complaints of X and X. There are X that continue including X and X. X has been in X and is noted to X. Exam of the X of X. X can only X to about X and X before X has X.

However, detailed documentation is not evident regarding continued participation in X.
Furthermore, guidelines state this is an alternative (on a case-by-case basis) "…to more X." However, documentation does not indicate failure of a X. This could plausibly be trialed prior to utilization of the requested X.

This X would not be considered an alternative to X at this time. There is no X or X noted to support the medical necessity of this request as an X to guidelines.
Therefore, the 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**

☐ **AHRQ- 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)**