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# 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 medical necessity of: X

## INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

## PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a X with a date of injury of X. The mechanism of injury is detailed as X and X resulting from X, X, X. The current diagnoses are documented as X and X. Prior treatment included X, X and X, X, X, X, X and X. According to an evaluation dated X, the claimant was seen regarding X. X and was rated X at X and X at X. On examination, X was present along the X. X was seen in the X and X. A X was seen. The claimant was recommended X. A request was submitted for X.

## ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Per evidence-based guidelines, and the records submitted, this request is not medically necessary. Per ODG, X are recommended for short term use only. The claimant complained of X and X. Pain X and was rated X. However, the examination on X to provide X, X, X, or X. Furthermore, there was a lack of recent clinical notes submitted to support the usage. X is also not warranted. Given the above, the request for X with X is not medically necessary. Therefore, this request is non-certified.

## 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**

- ☐ **AHCPR- 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)