MEDICAL EVALUATORS
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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 WHO REVIEWED THE DECISION

This case was reviewed by a X.

REVIEW OUTCOME

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

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The claimant is a X. Since that time, the pain has X. At its most X. X and X. X describes X and X as X.

X Report - X documented the claimant X was X. The claimant had X. X or X.

Clinical Report from X documented the claimant X was X. This started X. It was X. X by X. X by X. X was performed with the following impression: X of X.

Progress Notes by X documented the claimant reason for appointment is for X stating X is a very X who presents today in referral from Dr. X for evaluation of a X. X reports a X in the X that has been present for X. X findings included X. The claimant was diagnosed with X. Dr. X documented “Based on X clinical findings of X and a X, X recommend X. The X and rationale of the procedure are discussed in detail with the patient. X elects to proceed with X. Despite a X, the patient's clinical findings are X. X is not always the X as the X may X.

Prior denial letter from X denied the request for X stating “After careful review of all available information, our Specialty Advisor has determined that the proposed treatment does not meet medical necessity guidelines. We are unable to recommend the proposed treatment. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Evidence that a X was X to warrant the need for X was still not established. As X may be an option as delaying X until X, and X. Furthermore, it was noted in the X of the X that there was X. The actual X report was not submitted for review to verify findings. Clarification is needed for the request at this time and how it might change the treatment recommendations as well as the patient's clinical outcomes.”

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

The claimant is a X diagnosed with X and the request is for X with X.

A thorough review of the records indicate the claimant noticed a X that was X. X was diagnosed by X primary doctor with an X and recommended X. On X the claimant was seen in the X and evaluated for complaints of X. At the time an X was Xfor X and the claimant was X. The claimant then visited X the following day who did a through exam and diagnosed the claimant with X, X, and recommended X.

According to the review from X, the request for X was denied because the claimant X and the X was documented to be X" The X recommended X. This is not consistent with the current standard of care. The records indicate the claimant has a X that cause X. Dr. X completed a X and documented findings of a X. Furthermore, examinations like X are not always reliable for diagnosis of X especially since they are performed in the X. It should also be noted that X could be considered appropriate for an X with a X, not a X with a X.

Therefore, based on the referenced evidence-based medical literatures, as well as the clinical documentation stated above, it is the professional medical opinion of this reviewer that the request for coverage of X is medically necessary and appropriate for this claimant.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

1. **ODG Treatment/Disabilities Guidelines.**
2. **ODG Treatment/Disabilities Guidelines.**