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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:

X

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

Provide a description of the review outcome that clearly states whether **medical necessity exists** for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a X who was injured on X, when X was X. The patient sustained X.

Pre-Injury Records:

On X, X of the X from X revealed a X.

On X, X of the X from X revealed a X.

Post-Injury Records:

On X, X of the X were performed at X. The indication of the study was X. The study revealed X.

On X, a X of the X was performed at X. The indication of the X. The study revealed: 1) X. 2) X. X changes X. Findings had X. 3) X
On X, a X was performed at X. The indication of the study was X. The study revealed: X.

On X the patient was evaluated by X, M.D., for complaints of X. The patient reported X. The pain was X. There was X. The X was X. The pain X. X included X and X. The X included X. The pain was relieved by X. The history was notable for X. Examination of the X revealed X. There was X in X. X was X with X, X and X and X. X and X and X. X a X. There was X in the X and X. X revealed X. There was X in all X. X and X was X. X was X. X was X. The diagnoses were X and X. X and X were prescribed. X was recommended X. Ordered X and X.

On X, X of the X from X revealed X.

On X, X of the X revealed: X

On X, the patient was seen at X. The claimant presented with X. The symptoms were X. The treatment diagnoses were X. X was recommended X. From X, through X, the patient attended X with X.

On X, and X, the patient was seen in follow-up visits by Dr. X for X. There was X. X and X provided X. X of the X and X were reviewed. X and X was continued, and X was put on hold due to X. A X of the X and X were ordered.

On X, the patient was seen by X, M.D., for continued X and X. X had X. X provided help. X noted X after X. X and X provided relief in X. Examination revealed an X. The X had X and X. Examination of the X. The diagnoses were X and X. Dr. X noted that the patient's X. The plan was to X. The patient was X.

On X was performed at X. The study revealed: X.

On X, an X was performed at X. The study revealed: X.

On X, the patient was seen in a follow-up visit by Dr. X for ongoing X. The X. Dr. X noted the patient had X. X and X were continued. An X and X referral were provided. X was maintained.

On X, the patient was seen by X, M.D., for X and X. X noted X had X, but X continued to have X on the X. X also X. X was due to see a X, but the appointment was cancelled. X was now X. X pain was X and X was due to see an X. X remained on X and X. X, X due to X restrictions. On examination, the X had X. Pain X was noted. The X had X. There was X. The assessment was X. Awaiting visit by the X.

On X, the patient was seen by X, M.D., for X. The X, and X had a X. The pain was X. X was X. X has had X. History was notable for X. On examination, X was X. X was X. The X had X. X had X. X and X. X had a X. The assessment was X. The treatment plan included X.

On X, the patient was seen by X, X, who noted that X had X. X of the X showed X. X saw Dr. X for X, and X. X was scheduled to see X, Dr. X, for the X. X had X, but X continued to have X. X might also X. X remained on X. X was X. The plan was to follow-up with Dr. X in X and to see Dr. X for the X. Recommended continuing with X.

On X, the patient was seen by X M.D., for X. The X following an injury on X. The X. The pain was X. The X revealed X. X and X sign were X. was noted. X had pain with X. X of the X was reviewed. The X was X and X. Treatment recommendation included X and X. There was X.

On X, and X, the patient was seen by X, for X. X was seen by Dr X on X and would have X. The X. X would be seeing Dr. X in X. X needed X. On X was X. X was X. The assessment was X and X. X with X were prescribed.

On X, the patient was seen by Dr. X for X. X was scheduled for X on X. X had been approved for X. Awaiting approval of X for the. Recommended follow-up in.

On X, the patient was seen by Dr. X. X was doing X. X revealed a X. The assessment was X. Recommend X. X was advised to follow-up in X.

On X, the patient was seen at X. X was X. X complained of X. X recommended was X. From X, through X, the patient X.

On X, the patient was seen by Dr. X status post X. X most of the day. X had X. X was attending X, but it was X. X did some X. X had been taking X, but neither was very X. X continued to have pain in X, which X. X was to have an X, but it was being X. X was due to see Dr. X for follow-up of X and Dr. X. Examination of the X revealed X. The X had X with X. The diagnoses were X, status post X. X were prescribed. X and X together and to X. X was recommended to X.

From X, the patient was seen by Dr. X for X. X was status X. X continued to have X. On X, Dr. X noted that the patient had X. On X, Dr. X noted that the patient X. The treatment recommendation included use of X. X was advised no use of X.

On X, Dr. X noted that the patient was status X. Awaiting clearance by the X. Recommended follow-up on X, and schedule a follow-up for X if approved.

On X, Dr. X provided a X referral X.

On X, X, D.C., performed a X to determine the X and X. The patient had X, for the X. X was assigned a X.

On X, and X, the patient was seen in follow-up visits by X for X. X would be

seeing Dr. X, which was a different case and would see Dr X the following week for X. Dr X was waiting for clearance from Dr X to X. X had done X for X, and X stated that it was done on X. It was documented that the patient was X. X was placed X.

On X, Dr. X provided a X.

On X, an Authorization Request for X from X documented that X was requested.

On X, Dr. X requested a X. The patient might be a X. Recommended follow-up in X.

On X, and X, Dr. X noted that the patient's X. X also continued to have X. X was awaiting X by Dr. X after clearance by Dr. X. Recommended follow-up with Dr. X and Dr. X. The patient was advised no use of X. X was maintained.

On X, the patient was seen by Dr. X for X pain with X. X of the X was reviewed. The assessment was X. X was performed at the X. Recommended follow-up for a repeat X. X was recommended X.

On X, Dr. X saw the patient for X follow-up. X was doing X. X had X. X examination revealed X. X had got X in X. There was X. The assessment was X. Recommended X and X.

On X, Dr. X noted the patient was X with at X. X continued to have significant pain. At this point, X was a X. Requested X evaluation X to be done at X evaluation to be done at this office for a X, X. If X did well with this, X would be recommended.

On X, the patient was seen at X. On evaluation, X demonstrated the X based on the definitions developed by the US Department of Labor and outlined in the Dictionary of Occupational Titles. X was X.

On X, Dr. X noted that the patient was X. X has had an X, and X. The patient would be evaluated for a X as X was X. Examination X and X.

Recommended follow-up in X.

On X, the patient was seen by Dr. X in a follow-up visit. The patient continued to X. The diagnoses were X. Recommended X and to follow-up with Dr. X and Dr. X.

On X, Dr. X noted that the patient was X. X had X. X was X. X revealed X. X had X. X had X as well as X. The assessment was X. Recommended X and to follow-up in X and X.

On X, Dr. X saw the patient in a follow-up visit. A X was requested. X had a X performed and was X. X that X could be X. The X was X. The assessment was X. X was X and recommended follow-up as needed.

On X, the patient was seen by Dr. X for continued X. X reported that the X was denied. Dr. X released the patient to X. X was prescribed. Discussed X.

On X, the patient was seen by X, D.C., for an X. Based on the evaluation, the patient had X. The estimated date of X. According to the 4th Edition AMA Guides to the Evaluation of X, the patient was X. X would return for an X once X had X.

On X, the patient was seen by Dr. X for continued X and X. X had an X by Dr. X on X, and was X yet and was in need of X. X had attended the X and was not X. X requested to be changed to a different program, which X. A X was recommended to X.

Per Utilization Review dated X, by X, M.D., the request for X was deemed not medically necessary. Rationale: "*As noted in ODG's X. Here the patient's already X. ODG further notes that X. Here again, the patient has had X. It is unclear why the patient X. Therefore, X, evaluate and treatment is not medically necessary*."

Per a correspondence dated X, from X, the request for X and treatment was medically not certified by the X. It was deemed that the X requested did not meet established standards of medical necessity.

On X, the patient was seen at X for a X. X presented with X. X was status post X and also had X. At the time, X did not meet the current demands of the X. The treatment plan included X. Recommended X. (The medical document was incomplete).

Per a correspondence dated X, from X, a request for X. Requested additional medical documentation.

Per a correspondence dated X, from X, the request for X and treatment was upheld. As requested, a second contracted physician who was not involved in the original non-certification had reviewed the original information, supplemented by additional medical records submitted and/or peer discussion(s) with the treating provider. The second physician had upheld the original non-certification.

Per a Utilization Review dated X, by X, M.D., the request for X and X was not certified. Rationale: "*Per Official Disability Guidelines, "Consistent with all X does not X. Pre-screening for X is not recommended due to X." The claimant is a X. The initial mechanism of injury occurred while X. X is status X. X condition X. The guidelines support X. As noted by the prior reviewer, the claimant has been able to return to X and X condition is X. At this point, the guidelines recommend X. The guideline does not support the request. Therefore, the request is not medically necessary and is not certified.*" Reference Utilized: ODG, X.

On X, the patient was seen in a follow-up visit by Dr. X. With regards to X, the symptoms were improving but X continued to have X. The pain was X. X continued to have X. X the pain. X had been X. Examination of the X revealed X. There was X. X in all X. There was X. There was X. Pain at X was noted. X was X. X were prescribed. Treatment plan included X. Awaiting authorization for X. X was continued.

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

SUPPORT THE DECISION:

Based on the medical records the individual has X. The claimant has to X. The guidelines recommend X to an X and do not support the request. Therefore, the request for X is not medically necessary and is not certified." Reference Utilized: ODG.

X Not Medically Necessary

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES