*Applied Independent Review*
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***A description of the qualifications for each physician or other health care provider who reviewed the decision:***

X

***Description of the service or services in dispute:***

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 who was injured on X. X stated X was X. X injured X in the process. The diagnosis was X. An office visit note by X, MD dated X was documented. X presented for follow-up. X continued to have X. X had required X. X did see a primary care physician who took X. X was again denied on the basis that the reviewer felt X. Dr. X would remind the next reviewer that it had been X since X. Since X injury, X had X. The X were begun by X. X was in X. X had been X. To suggest X would require X was not a judicious utilization of resources. X understood the X completely, and again, was in X. In regard to the suggestion of a X, X had already undergone a X. This was the X. Furthermore, studies recently had shown that there was an X. Furthermore, the COVID virus was still present and X could X. X had been doing X. This included X. Again, X showed evidence

of X, which was at X. This was a X. In regard to X, this should immediately exceed ODG guidelines. Examination of the X. This caused X. A X were noted. X was noted over the X and the X. This was consistent with X. X in both X and X. X was noted with X. This also caused the X. This was X. X was also X. It was again X. X remained X. The assessment was X and X. In summary, Dr. X noted that in regard to X usual and X this in and of itself should not exceed ODG guidelines. Also, it had been X. In regard to X. X was an X. X had been doing X. X offered X. X mechanism of injury was consistent with X. X was X. X continued to have an X with a X. X also had X. X also required X. The recommendation at the time was that of an independent review organization (IRO) determination that would agree with the above. This was further adding cost to X claim, as X would eventually X. This had been a X. X would continue with X. X had been X, however, by X other X in regard to the fact that X was X. X was given a X that day as a medical necessity.

An X, identified X.

Treatment to date X.

Per a utilization review adverse determination letter dated X, X, MD denied the request for X. Rationale: “Per evidenced-based guidelines, X is indicated for patients with X. The patient was recommended X. However, there was limited documentation of pertinent subjective complaints and significant objective findings to fully meet the criteria and justify the need for the request. There was limited documentation that the patient had exhausted all X.

Clarification is needed regarding the request and how it might affect the patient's clinical outcomes. As the requested X had not been deemed medically necessary, the X request is thereby not substantiated. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified.”

Per a reconsideration review adverse determination letter dated X, MD denied the appeal request for X. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced above, this request is non-certified. Detailed objective evidence of a recent, X and X. Official reports of prior X rendered on the X was still not submitted for review. X

made multiple attempts to contact the X to garner additional information or exceptional circumstances. This was unsuccessful. Therefore, based upon the provided documentation, the request is not currently supported and the prior non-certification is upheld."

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

The claimant had been followed for X. X were evident. The claimant had X. The records did not document failure of reasonable non-operative measures to include X. Without documentation showing clear failure of non-operative measures, it is this reviewer's medical assessment that medical necessity is not established and the prior denials are upheld.

***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 um knowledgebase 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 Internal 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 Médical **Literature** (Provide a description)

- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)