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Notice of Independent Review Decision

Description of the service or services in dispute:
X

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified X
Board Certified 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 is a X who was injured on X. X had X. The diagnosis was X.

On X, X, MD evaluated X for the chief complaint of X. X reported X. X had X on X with X. X had X with X who wanted X. X reported X. X suffered from X. X goals for X included X. Examination of X noted X. An office visit dated X by X, was documented. X reported X. X reported the X. X had been done in X with X. This was X but was X. X had X on X with X. X had a follow-up with Dr. X who wanted him to X on X. Examination of the X noted X.

Per the X office visit note, X was done and confirmed X.

Treatment to date X.

Per a utilization review adverse determination letter dated X, and a peer review dated X, the request for X was denied by X. Rationale: X. Therefore, X is not medically necessary."

Per a utilization review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "The Official Disability Guidelines supports X if there is X. Additionally, Official Disability Guidelines does not support the use of X in X. Within the medical information available for review, there is documentation of a request for X. Additionally, the patient has X. Also, the patient had X. However, given no evidence of X, the X findings do not corroborate the diagnosis of X. The guideline does not support the request. Therefore, the request is not medically necessary and is not certified."

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

As noted in prior physician reviews, the medical records at this time do not clearly establish the diagnosis of X. Moreover, it is not clear that this claimant had X. Overall, no significant new details have been provided since the prior determinations. Therefore, the request remains not medically necessary.

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
- ☐ 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

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