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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:

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 sustained an injury on X. While X. The diagnoses included X.

X was seen by X on X. X presented with X that occurred on X from X. X stated that X. X had pain in X with X and X. X stated X. On examination, X demonstrated X. X had difficulty X. There was X with X. X was X and X. X was unable to X. X used a X for X. X demonstrated an X with X. X in the X

was X and in the X. X was X and X was X. X was X to X. X required X to X with X and X.
A X re-evaluation was performed by X on X. X reported no X. X continued to have X. X had continued X with X. X had continued X. X on X and X was X. X was X. X was X and X was X. X was X. X required X.
Treatment to date included X.
Per a utilization review by X, MD on X, the request for X was non-certified. Rationale: “Regarding X, ODG notes that X is recommended for patients with X. In addition to X, the claimant was authorized X on X referral X. There is no discussion regarding outcome or benefit from this prior treatment. There is no support for continued treatment absent documented improvement. Recommend non-certification.”

Per a utilization review by X on X, the request for X was non-certified. Rationale: “Per the Official Disability Guidelines (ODG), X, X is generally required early on following X. Allow for X, plus X. X." Per the Official Disability Guidelines (ODG), X, "Recommended for patients with X." According to treatment guidelines, a patient should be making progress to continuation of care. In this case, it is well documented that the patient is not X. Therefore, X would not be warranted. As such, the requested X 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.

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review by X, MD on X, the request for X was non-certified. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is a lack of documentation of significant and sustained improvement as a result of treatment completed to date. Current evidence based guidelines would support X if X. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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)