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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

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, when X was X and X noted a X, X and X. The diagnosis was X.

On X, X, DO evaluated X who presented for further care of X, X and X, X and X, which was again quite evident in X area preventing X from X and at X. X could X at the X. X also had X, X, and X. X was on X is on X. X again were X and X into X. Dr. X noted this was not X, it was X, and recommended X. X documented this was X. It was acceptable under the ODG guidelines. Any further delays would lead to X and X. X were X.

An X dated X, showed a X, resulting in some X. X was noted that may be X or X. There were some X changes otherwise without other X.

Treatment to date included X including X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Per the ODG, X are not recommended as the use of X has not been shown to provide significant benefit over the use of a X alone. The available medical records do not indicate why a X would be necessary in this case. As the requested X is not recommended due to a lack of supporting data, the request is not supported. Therefore, the requested X is non-certified.”

Per a utilization review adverse determination letter dated X, the reconsideration request for X was denied by X, MD. Rationale: “The X has X. The provider is requesting X. X are not supported by evidence-based guidelines. No exceptional factors noted. Therefore, the request for X is non-certified.”

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

The request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no clear rationale provided to support the use of X guideline recommendations. The total X being requested is unclear. It is unclear if there are ongoing active treatment modalities being utilized in conjunction with 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)