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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 between X.

X was X and was X. X must have been X not to be X because a X. That new X which X. X sustained injuries to X.

On X, a X of the X was performed at X. The study revealed: X

On X, X and X was performed at X. Indication for the study was X and X. The study revealed: 1) X to the X. 2) X injury to the X.

On X, CT of the X and X was performed at X. Indication for the study was X, X, X. The study revealed: 1) No evidence of X. 2) No evidence of X to the X.

On X, X of the X were performed at X. The study revealed: 1) No X injury.

On X, X of the X were performed at X. The study revealed: 1) X or X. 2) X of X with X. 3) X. X was X by overlying X.

On X, a X of the X was performed at X. Indication for the study was X and X. The study revealed: 1) There was an X, X and although there was X, there was no X. 2) X and X was seen at the X and X. There was X on the X; however, X was seen. 3) Very X was seen in the X. This was in the X. The X usually X. X might be helpful or necessary to evaluate this further as clinically directed.

On X, an X of the X was performed at X. Indication for the study was X and X. The study revealed: 1) X was seen at X. 2) There were X in the X. There was no X in the X. This was either a X or a X, X, X and X. X of both X were noted.

On X, an X study X of the X was performed by X, X. The indication for the study was X from X into the X. The study revealed: 1) X findings did not indicate any evidence of X findings

in the X. 2) X data obtained revealed X and X. Collectively, the X might indicate a X, X. Follow-up with the referring provider was recommended.

On X, the patient was evaluated by X, M.D., in a follow-up for X and X and X. A X, a X and X was recommended in the last evaluation. Reportedly, X did not complete any of the recommended treatments as X was under the impression that the recommended treatments were the same treatments that X previously underwent which were ineffective. On examination, the X was X and X. The X had X. X was X. There was X noted of the X and X. The X was X. MRIs of the X and X were reviewed. X of the X revealed X at the X. The diagnoses were X and X. Treatment recommendations included X of the X and X. The patient was advised to follow-up in X.

Per a referral dated X, by Dr. X, the patient was recommended X with X.

On X, the patient was evaluated by X, D.C., for pain in the X and X. The onset of the pain was following a X on X. X was between X. X was X from the X and was X. X must have been X. That X was X which X. X sustained injuries to X. X went to Hospital immediately and was also seen at X. At present, X reported constant pain. X reported that X was denied as X had not had the X. X stated that X did not really want the X as X did not think it was a X. X would be discussing the same with the X. Examination of the X revealed X and X and X. There was X. X pain. On X, X and X were X. Examination of the X revealed X and X in all X. X was X. X was X overall at X. X was X. Examination of the X revealed X and X. X was noted in the X. There was pain on X. There was X in all X. There was X and X X. X was X with pain. X and X were also X. X was X. The X was X. The X were X. The diagnoses were X, X and X. Treatment recommendations included X, follow-up with X and to

continue X.

On X, the patient was evaluated by X, D.O., for X. X was involved in a X. X was seen at X Hospital and X. X had been on some X and some X. X did not have any X. X initially X and X. X was being referred for a X. On examination, X was noted to have some X. X had to use a X. X had X of the X. X had apparent X. X was reviewed. X reports were not available for review. The assessment was X. Dr. X noted that the patient would be a candidate for X since X had X and X. X was noted to have a X, but the plan was to concentrate on the X.

On X, Dr. X submitted a referral for X.

On X, a Pre-Authorization Request for X was documented. The requested service was X along with X.

Per a Utilization Review dated X, by X, M.D., the request for X was certified based on the following criteria: ODG X-Online X. Rationale: "*X." According to the guidelines, X are recommended as an X with X when X. A successful peer-to-peer call with X, DO was made at X. The details of the request were discussed. According to the provider, the X has X and X. The X has also X and states that the X has X. The provider states that the X did have some X and X. The provider explained that the X had been sent to a X who recommended an X and referred the X to the requesting physician. The provider states that the intent is to provide the X with X from them. Based on the information provided in the available medical records, the request is compliant with the ODG guidelines and is medically necessary*." Addendum: "*A successful peer-to-peer call with X DO was made at X. The details of the request were discussed. According to the provider, the X has X and X including X, X and X. The X has also X and states that the X has X that X. The provider states that the X did have X. The provider explained that the X had been sent to*

a X who recommended an X and referred the X to the requesting physician. The provider states that the intent is to provide the X with X efforts and X from them."

On X, the patient was seen in a follow-up by Dr. X. X came in to better understand the X. It was approved at this time but was denied initially. The assessment was X. The treatment plan was X due to X broad-based X. A X approach was recommended to avoid a chance of a X. X was advised for patient's X. Since X had this problem for X, the patient might require more than X. X was recommended X.

On X, the patient was seen by X, NP, for continued X, X and X following an X on X. X admitted pain X and denied any X and X. X was collected for X. On examination, X was noted. The diagnoses were X, X. The patient was advised to follow-up with the X. Treatment recommendations included X.

On X, and X, the patient was seen in a follow-up by Dr. X for continued pain and X. X wanted someone to do the X for X. X noted that X, but X did not want to X as they caused X. Treatment plan was to get an X.

On X, X from X was X and X and X and X. The study was X and X, X, X and X.

On X, the patient was seen by X, D.O., for an X evaluation. X sustained a X on X. X reported X was X and as X related, X became quite X and X and the X. Since that time, X has had X and X. X was referred here for X. X of the X and X were X. This was also associated with a X. X with an X. X had X into X and X. X became X. X admitted to X, X, and X and X. X was X. X today showed and was consistent with that reporting as X was X, X, X, X, and X were all admitted. X or X was X; X. X intake X was consistent with the X on X which was checked to X. X reported

that this X. The X, X and X rated at X, and X, X, and X with X and X. X were X. At present, X reported that X felt like X had been X. On examination, X with an X and X a X. The X was X with X and X. X had some X. X had X. There was pain with X. X into X was noted with X. X had X in X as compared to X. X throughout the X were noted. X was X with X. X had X. X had a X and a X. There was X. X of the X. The assessment was X with X and X. The patient's X was X. Initial medical management first would be aimed at the X and X. X and X were X. Once X of this X improved affect, improved X would be achieved. A X would be recommended. X would be a direct approach for X. Once X of X was X.

On X, Dr. X saw the patient for continued X into X and X. X felt the X. X was receiving a X. X reported X and X. As a result, X wanted to go ahead with a X for X and X. The X was X in X. Treatment plan included a X and X associated with X. The patient was advised to X or that might cause any X.

Per a Utilization Review dated X, by X, M.D., the request for X under X was non-certified based on the following criteria: ODG X online X, X. Rationale: "*Recommended as a short-term treatment for X, X, and/or X. This treatment should be administered in X efforts including X. Not recommended for treatment of X unless there are X findings on exam. X are not recommended as a treatment for X or for X. X at X are not recommended. See X for use below. X must be well documented, along with objective X on X. X must be X and when X, unless documented pain, X. A request for the procedure in a patient with X requires additional documentation of X associated with X. X is not generally recommended. When required for X, a patient should remain X. In this case, there are X and X. However, there is no record of X that would X for this procedure. X is not recommended and there is no record of factors that would indicate such X as to require the involvement of an X. X is not shown to be medically necessary.*

Therefore, the request for X is not medically necessary."

Per a correspondence dated X, from X, a request was received for Utilization Review of X provided to the patient. This correspondence served as a notification that the requested medical treatment did not meet established criteria for medical necessity based on the peer review completed by Dr. X. The requested service was X between X, and X. UR Determination by Dr. X. "*Recommended as a X for X, and/or X. This treatment should be administered in X and/or X. Not recommended for treatment of X resulting in X unless there are X on exam. X are not recommended as a treatment for X or for X. X at X are not recommended. See specific criteria for use below. X must be well documented, along with X findings on X. X must be corroborated by imaging studies and when appropriate, X, unless documented X, X and X support a X. A request for the X in a patient with X requires X. X is not generally recommended. When required for X, a patient should remain X. In this case, there are signs and symptoms of X findings. However, there is no record of X that would X for this procedure. X is not recommended and there is no record of factors that would indicate such X as to require the involvement of an X or X. Monitored X is not shown to be medically necessary. Therefore, the request for X is not medically Necessary."*

On X, Dr. X noted that the patient continued to X and X. X had X and X and into X. X had a X on the X. X had X and X at this level due to X. X had X with X. They were awaiting approval for X as the patient was getting more and X. X was diagnosed in a X approach to include the X and X. X had an X. A peer review physician who reviewed this case had denied reasonable, necessary treatment under the ODG guideline and supported by the Texas Medical Board. They were trying to avoid X. X was X, X and X. Dr. X further stated "The doctor cited no X and X, well that was X doctor. X should have looked at the X, X should have

X. They have concluded that this patient had X and X associated with X, X injury, X and X and X. As a result of this denial, X were having to X. X are having to send this X again with X and X at X and X. All indications point towards the X. Due to X which was quite evident here today as noted on physical examination as well as X, a X approach at X should go a X. X will arrange for this as soon as possible." The plan was to resubmit for X. This is a X and not X as suggested. Dr. X stated "X do not use X; we used a combination of X and a X and allow us to effectively carry out as practiced by this Board Certified X. In the meantime, the patient's X was consistent with these agents. There was no evidence of X. X was satisfactory."

On X, Dr. X submitted a Request for Appeal/Reconsideration. The requested service was X between X, and X.

Per a correspondence dated X, X, the Utilization Review Agent on behalf of X, notified that they received a request for reconsideration of an adverse utilization review determination related to the patient. The requested service was X between X, and X."

Per a Utilization Review dated X, by X, M.D., the request for X was non-certified based on the following criteria: ODG X online version, X. Rationale: X. *According to the documentation, the X presented with complaints of X and X and X of X. The pain is associated with X and X. On examination, there is an X. The X was X. However, the X was X. X throughout the X were noted. X was X with X. The X had X. Noted X in X was noted. Overall diagnoses include X. The X dated X and either a X. In this case, the X presented with complaints of X. There is a request for a X. The X has had a X. However, there was no documented improvement X in or a X from the X noted as required by the guidelines. X this request is not medically necessary."*

Per a correspondence dated X from X, the request for reconsideration of a previous non-certification was reviewed by a peer reviewer who was not involved in the original determination. Based on this reconsideration review by Dr. X, it had been determined that the requested medical treatment did not meet the established criteria for medical necessity, therefore the original determination was upheld. The request for X was non-certified. "*Recommended as a X. Patient criteria for X: X. The pain is associated with X and X. On examination, there is an X. The X for X was X. However, the X was X. X throughout the X were noted. X was X. The injured X. Noted X. X was noted. X include X and X. The X of the X dated X showed X, X. In this case, the injured worker presented with complaints of X. There is a request for a X. The injured worker has had a prior X. However, there was no documented X noted as required by the guidelines. Hence this request is not medically necessary."*

On X, Dr. X noted that the patient continued to have X. A referral to X was provided with Dr. X as this patient had X and medical treatment options. X was recently denied X. X was taking X, however, compliantly including X. and X for X. Dr. X reported the patient had X and pain in the X. X was referred for a X evaluation and treatment as requested.

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

According to the documentation, the injured worker presented with complaints of X. The pain is associated with X.
The patient had Xas document ted per record of the chart with a X as well as X, at X. The study revealed: X. There was X. This was either a X. Contact of both X were noted. The X noted X. This X may be indicative of X. The above studies X as noted by Dr. X. A referral X was provided with Dr. X as this patient had X.

X was diagnosed in X approach to include the X and X. X is indicated for X and is medically necessary in this case for a X. The criteria as set by the ODG has been met for X and is certified medically necessary.

☒ Medically Necessary

☐ Not Medically Necessary

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

☒**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**