IMED, INC.

PO Box 558* Melissa, TX 75454

Office: 214-223-6105 * Fax: 469-283-2928 * email: @msn.com

Notice of Independent

Review Decision

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 whose date of injury is X. A X. The patient underwent X with X. The patient reports that while doing X and had to go to the X. The patient underwent X. X dated X indicates that the patient underwent X. The patient

was authorized for X. On X it is reported that the patient had a re-exam with Dr. X and the patient had X. It was determined that the patient X on or about X but has not yet reached clinical X as the patient continues to have X. X also continues to have a X. Chart note dated X indicates that the patient saw a X with X; however, it does not include the X which is part of X. Current medication is X. On exam X. X of the X noted findings of X. X of the X noted X. X was X. X was X in the X. X is X. Assessment notes X. Follow up visit dated X that X is currently taking X, X and X and is X. X presents with a X. X pain is X, X, and X. X, on the X. X is X. There is X to X. X: X. X is X. Diagnosis: pain in X.

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. The initial request was non-certified noting that ODG states "Allow for X. X: Medical treatment: X. In this case the claimant has been X beyond guideline recommendations. There is no association with the X and X. X has been authorized for X to date. There is no discussion of X made with care completed. Therefore, this request is not medically necessary and is not certified. The denial was upheld on appeal noting that the operative report was not submitted for review. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient underwent X on X and has completed a X. The request for X would exceed guidelines. When treatment X exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient has completed X and should be capable of continuing to X.

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

X MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES