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Review Outcome

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 was injured on X. X was X when X. The diagnosis was X.

X was evaluated by X, MD on X for complaints of X. X was X for X. X was able to X for X. The pain level was X at the time. Pain level at the X was X, and X was X. The X was described as X. "X." X had been denied on appeal. Examination noted X since the prior office visit. There was pain in X. Examination on X again noted X in the X since the prior office visit. X was noted with X. There was X, and X on X.

An X of the X dated X. No X was seen. At X, there was X. At X, there was X. X was seen without X. At X, there was X. No X was seen.

Treatment to date was X including X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD as not medically necessary. Rationale: Per ODG, Diagnostic X for X was "Recommended prior to considering X. Not recommended in X." There were no documented X to support an exception to the guidelines. X were not shown to be medically necessary.

Per a reconsideration review adverse determination letter dated X, the request for X was denied by X MD. Rationale: “The patient has X after X. The patient reports X with X. X are not recommended in X. There are no documented extenuating circumstances to support an exception to the guidelines. The request is not medically necessary.”

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. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that the X is not recommended for X. Pain due to X is X in the X, where there is X due to X. X of X also presents a X, where recommendation for diagnostic or therapeutic purposes has been precluded by a 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)