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Notice of Independent Review Decision

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:
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 sustained an injury on X due to X. X was diagnosed with X.

X was evaluated by X, FNP / X, DO on X for X ongoing symptoms including X. X complained of X. The X with the X. The X was rated at X. On examination of the X, there was X. X was X and X. There was X. Dr. X recommended continuation of existing treatment plan.

On X, X was evaluated by X, DPT. X continued to report X. The symptoms were related to X. X felt that it was X. X also reported continued X. X stated that X had X. X was not able to X. X had difficulty with X. On examination, X demonstrated X in X and X.

An MRI of the X dated X revealed a X. This was X. A X was seen X. This was X, X, and X with X from X. A X was seen at X. This was X; however, there was X. There was a X. This was X, X, and X with X.

Treatment to date included X, X with X, and X.

Per a Utilization Review decision letter dated X, the request for X was denied by X, DO. Rationale: “Based on the clinical information submitted for this review, and using evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The objective findings were not adequate to support X and support the need for X. After reviewing the information provided, this request will be deemed as non-certified”.

Per an adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, the recommended X is X. An appeal request was made for X. However, the previous denials of the request were not addressed to warrant the current request. Objective findings were still not adequate to support X and support the need for X. Also, the request exceeds the recommended X per guidelines. Furthermore,

there should be no more than X, allowing the X to focus on X. No exceptional factors noted".

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

X reviews previously have noted that this claimant has undergone X and the claimant would be expected to have X. No significant additional information has been provided for an exception to those prior recommendations. It is unclear why X rather than X is indicated. Moreover, a rationale for X rather than X at this time is not apparent. For these multiple reasons, this request is not medically necessary.

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)