Independent Resolutions Inc.

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Notice of Independent Review Decision

Amended Letter

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who was injured on X, with a X and X from X on X and X and X in the X. X was diagnosed with X. On X, X was evaluated by X, MD. X reported X that X following recent X. Examination of the X revealed a X, a X, a X, and X on X. Dr. X recommended X under imaging guidance. On X, Dr. X noted X was rated at X and described as X, X, X, X, X and X and X. Examination showed X, X, X and X, and X and X. X was diagnosed with a X. Other than the previously mentioned information, no additional clinical findings to support the need for this care were made available with this review. Dr. X was appealing the prior determination at this time. An X dated X identified X and X. X of the X and X was X. Treatment to date included X and X. Per Utilization Review dated X, the request for X under imaging guidance between X and X was denied by X, MD. Rationale: “The Official

Disability Guidelines stated X are not recommended, including X / X (for example, in X). X are not recommended as there is X that can be recommended based on any X are not recommended for X). X can be made if the X is required for X recommended X. The authors indicated it was not clear if image-guided X of a X to a X. The requested X, X is not supported at this time. In addition to the lack of guideline support, there does not appear to be any indication that X is being considered. Hence, the request for X Is non-certified." Per Appeal Review dated X, X, MD upheld the denied request for X between X and X. Rationale: "Regarding a X, the Official Disability Guideline (ODG) states it is not recommended. Regarding imaging guidance, the ODG indicates X in the X include X, X, X, X, and X. The X to important X, X, and X can make use of X worthwhile for in-office X. Based upon a review of the submitted records, the prior non-certification appears to have been appropriate. The guidelines do not support performing this type of X. Given there is X and guideline support for this procedure for the treatment of X, the requested X is non-certified."

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

X agree with the denial as evidence based guidelines do not support this X-X. Per ODG, X are not recommended as there is no further definitive treatment that can be recommended based on any X information potentially rendered (as X are not recommended for X).

With no clear benefit in doing the X, medical necessity would not be established.

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

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR 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 & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL