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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. X stated X was X when the X. X of the X and X. X immediately noticed X. The diagnosis was X, current injury, X; X, X; aftercare following X of the X; and X. X, MD evaluated X on X for a follow-up for the X. X presented for X visit of a X and X. X continued to have some X with X and X. X had completed X. X complained of X pain with X. On examination of the X, the X showed X, X, and X. The X was not X. X testing was X. The X was X and not X. X was X. X was present to the X, X and X, and all X. X were X. The X was X. There was X and X and X. The X were completely X. X showed X and X. An MRI of the X dated X identified a X of the X; X; X in the X and X; X and X; X; and X. X, X, and X were

obtained on X. X were compared to previous X and revealed X. There was no new X or X. Treatment to date included X, X, X, X, X, and X and X on X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "ODG recommends X as an X for X who have not responded X. The claimant is noted to have X and X. There is no X. The request is not consistent with ODG." Per a Preauthorization request for X dated X, "The medical provider, Dt. X, has requested this medical treatment because there is an ongoing condition(s) that requires treatment, the recommended treatment X; and the recommended X. The X is reasonable due to X despite X and X, and is consistent with the Official Disability Guideline (ODG)."Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: "There is no evidence of X to support X to X. ODG recommends X when there is a X, X, and X. The provided documentation indicates the patient underwent X and X on X. X has X despite X and X. X imaging showed evidence of X. There is no evidence of X to support progression to X. As such, X is not medically necessary."

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

The ODG supports X for the treatment of X after a X and X including X for X as a means to X. The documentation provided indicates that the worker reports X following X and X. Treatment has included X and X. An exam of the X documented X, X, and X. Imaging is documented X in the X. The treating provider has recommended X with X. When noting that there has not been a X of a X would not be supported.

As such, X is not supported as medically necessary.

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