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Notice of Independent Review Decision

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 who was injured on X. The mechanism of injury was not documented in the records. X reported X was X on a X from X and was not in a X. When X returned to X, X had started X again and the X. The diagnoses included X, X was seen by X for a follow up visit regarding X. X rated X. X was taking X. X reported X would be on X. X reported that the pain had initially started in X while X in X. X was evaluated at X and was also at some point seen by X did not recall the type of tests that were performed at that time, but thought that they had done some X and was told that everything X. X PCP also tested X for X. X was referred for X.) X reported that X did not know if the pain had resolved completely but it no longer interfered with X daily activities. X reported X was X from X. When X returned to X had to start X and the pain slowly returned. X reported the pain was X. The pain involved X. There was X. X was taking X as needed. X had used X but never felt it was helpful. X denied any other symptoms. On examination of X, there was X. The assessment included X. X was recommended continuing X as directed and a X was ordered. X declined X. Treatment to date included medications X. Per a utilization review

adverse determination letter / peer review report dated X, by X, MD, the request for X was not medically necessary. Rationale: “No, the request for X is not medically necessary. While ODG's X Chapter Electrodiagnostic Studies topic acknowledges that X are recommended in patients with clinical signs of X who may be X, here, however, there was no mention of either the attending provider or the claimant's willingness to potentially act on the results of the study in question and / or go on to X. Therefore, the request is not medically necessary, Therefore, X", not medically necessary.” Per a utilization review adverse determination letter dated X, MD, the request for X was not medically necessary. Rationale: “The history and documentation do not objectively support the request for X at this time. The ODG state "Recommended as an option after X. Also, recommended for X. For more information, see the X. " In this case, there is no clear evidence of a X. There are X. X history of evaluation and treatment to date is X. There is no evidence that X is under consideration. The medical necessity of this request has not clearly been demonstrated and a clarification was not obtained. Therefore, X" is not medically necessary.” Per an appeal letter dated X, it was documented that as requested, a second contracted physician who was not involved in the original non-certification had reviewed the original information, supplemented by additional medical records submitted and / or peer discussion(s) with the treating provider. The second physician had upheld the original non-certification.

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 X. There is. There is X completed to date or the patient's response thereto submitted for review. There X for review. There X for review.

Therefore, medical necessity is not established in accordance with current evidence based guidelines for the request of X.

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