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Notice of Independent Review Decision
Amendment X

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:

☐ Overturned Disagree

☐ Partially Overtuned Agree in part/Disagree in part

☒ Upheld Agree

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. The biomechanics of the injury is X. The assessment was X. On X, X, MD evaluated X for a follow-up of X. X was X. X had developed X. At the time of the visit, X reported that since X, X had quite a X. X had X. Then X had a X. Since that time, X had X. X saw X PCP and had an X. X also had a X. X continued to have X. X denied any X. X last X. X had quite a X. On complete X examination, X had X. X of the X

revealed X. X were X. X examination revealed X. X examination was X. X was noted in the X. X was X. It was believed that it could be a X. Per the note, an X dated X showed a X. X on X showed X. X was reduced to X. At X. The X was reduced to X. At X, there was a X. X was X. X dated X revealed a X. There was X. X Program was X. It was noted that due to X, A X , as well as x of the X , was requested. Treatment to date included X.Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Based on the submitted clinical notes, the claimant had a X on X. The need for X is also deemed not medically necessary as there have been no significant changes on examination since the last X were obtained. Hence, the requests for X are deemed not medically necessary. Dr. X completed an appeal letter dated X and stated “X is X. X has developed X. X is noted at X. X at X reduced to X. X has had increased X. This had worsened to the point that the X. We are requesting an X of the X due to the X. Unfortunately, this has been denied, and we would like to appeal this denial. “Per a reconsideration review adverse determination letter dated X by X, MD the request for X was denied. Rationale: “Per ODG, X is not routinely recommended and X. The claimant had reported X ; however, the most recent X exam X. All information made available for review and in consideration of evidence-based guidelines, the requests for X not medically necessary and hence the previous non-certification is upheld. “The ODG supports X when there has been a X. The ODG recommends X for the evaluation of X. The X supports X. The documentation provided indicates that the injured worker X. They have developed X. They reported X. They had a X which was X. They continue to have X. On exam there is X. X on X documented a X. An X on X documented a X. The provider has recommended X. When noting that there is X. Additionally, the worker has had a X. As such, X are not medically necessary and noncertified.

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

The ODG supports X. The X recommends X. The X. The documentation provided indicates that the injured worker X. They have X. They reported X. They had a X. They continue to have X. On exam there is X. X on X documented a X. An X on X documented a X. The provider has recommended X. When noting that there is X. Additionally, the worker has had a X. As such, X are not medically necessary and

noncertified.
Upheld

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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF X**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**