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Notice of Independent Review Decision

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 Overturned (Disagree)

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]:

The patient is a X who was injured on X, when the patient was involved in a X. The patient was X. X. X was X. There was X. X cannot X. X was able to X.

On X, a X showed X. X significant X. X. Findings demonstrated the X was X. The X were in X. X. The X were X. The X terminated at the X. The X were X. X was noted at X. X. X: X significant X:X: X and X. X:X. X:X.

On X, the patient was seen by X, M.D., status X on X. The patient complained of X. Following X on X, the patient was X. Since the accident, the patient had X. X had X. X was X. X had X. On exam, X was X. X had to X. X revealed X. X was limited. X. X performance was X. X had X. X evaluation demonstrated an X. The diagnoses were X. Review of X showed X. X was placed on X.

On X, the patient was seen by Dr. X. The patient continued to get X. The X. X had to call X. X was X. On exam, X was X. X had to keep X. X had X in X. X revealed X. There was X. X were X. X performance was X. X was X. X evaluation demonstrated X. The diagnoses were X. Plan was to continue with X and would most likely follow up with Dr. X.

On X, the patient was seen by Dr. X. The patient continued to get X. The X was X. X had X. A X was X. Plan was a referral to X.

On X, the patient was seen by Dr. X. The patient reported the X. X had an appointment scheduled with Dr. X.

On X, the patient was seen by X, M.D., for X. On exam, X was X. There was X. There was X. The diagnoses were X. X was X. X had treated this with a

X. X had X. Dr. X believed X.

On X, the patient was seen by Dr. X. The patient had seen the X. X did have X. On exam, X appeared to be X. X had X. X revealed X. X was X. X were X. X performance was X. X was X. X evaluation demonstrated X. The diagnoses were X. X was considered at this visit but X. Plan was to follow up in the X.

On X, the patient was seen by Dr. X. The X Dr. X requested was denied. X reported a X. X thought X might X. X had resolved but X. X reported the X. Plan was to follow up in the X.

On X, the patient was seen by Dr.X, X. The patient had X. The patient was X. Plan was to follow up in the X.

On X, a X performed at X showed: X.

On X, the patient was seen by Dr.X. The patient had X. X continued to get X. X reported X. X went to X on X, for X. A X had findings of concern of X. X was completed. X was to follow up.

On X, the patient was seen by Dr. X in a follow-up visit for X. The patient continued to have X. X was X. On exam, X. There was X. The diagnoses were X. X had completed the X. X continued to have X. It was believed X would be X. X could follow up on X.

On X, the patient was seen by Dr. X. The patient reported X. X management referral was X. X was continued on X.

On X, the patient was seen by X, M.D., for X rated at X. X was X. X was having X. X made it X. X had X. On exam, X was X. X were X. X were X. X had X along the X. The diagnosis was X. X was X. Plan was to get a X.

On X, a Utilization Review from X indicated evaluation with X for X.

On X, a X from X was documented. The patient was X. The patient demonstrated the X. X was X. The patient demonstrated the X. The X

questionnaire was performed, and the patient scored X. The patient performed the X Questionnaire and scored a X. The patient also performed the X Questionnaire and scored a X. X Questionnaire was performed and the patient scored at a X. X remained the X. These patients required X. This level might X. Following overall functional testing, X heart rate was X.

On X, a correspondence by Dr. X indicated X. The patient's X was X. The X should have X. X was X.

On X, the patient was seen by Dr. X. Dr. X was requesting a X. The patient X. The patient would X. The treatment X. X would benefit from the X. The patient was X. Objectively with X, X reduced X, X was X. X on X for X. X is reported to be X. X. On the X evaluation, the X states X. However, the X notes X work X.

On X, a Peer Review by X, M.D., indicated the requested service of X was non-certified. Rationale: "*The principal reason(s) for denying these services or treatment: The patient has documented X. X has X. Previous methods of treating X. The ODG criteria for a X. The patient had a X. X was attempting to get to a X. There is X. The X indicated X had X. By X, Dr. X reports that the patient X. However, X has not attempted a X. X are X. X has X. X does not meet the ODG criteria for X. Therefore, my recommendation is to NON-CERTIFY the request for X. GUIDELINES/REFERENCES: GUIDELINES/ REFERENCES; X. ODG by X. ODG X.*"

Per reconsideration dated X, the request for X.

On X, Dr. X filed an appeal against the denial of the service. X was X. The patient did X. The patient had X. X was denied X. X completed X. Previously, X was denied due to X. Both of these have been completed and X continued to have X. The specialist documented that X had a X. The X reported that X. The X also reported that X. X was retested with the X. The X reported that there was X. The X had documented X had an injury X. This seemed like a reason that X was X. X was X. X did receive a X dated X. X lessened in X. A X for X did meet the ODG. X would X.

On X, a Peer Review by X, M.D., indicated the requested service of X was

non-certified. Rationale: "*The principal reason(s) for denying these services or treatment: The patient does not meet the ODG criteria for a X. The patient showed X. The clinical basis for denying these services or treatment: The ODG requires that X. The peer review on X non-certified the request for X. It was not that X has X. After the X was certified on X, the X. The patient had marked X. Yet, there had X. The provider submitted an X from X; however, these results were when the patient had documented X. X had not had an X. The patient has X. The provider has not provided a X. The patient does not meet the ODG criteria for the X. Therefore, my recommendation is to NON-CERTIFY the request for X. X.*"

Per the Utilization Review from X dated X , the request for X was denied as not medically necessary or appropriate. (Rationale was not provided).

An undated X Request from X indicated the requested X.

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

The ODG criteria for a X. The patient had a X. X was attempting to get to a X. X is X. An X evaluation has been made. X due to X. Patient has been X. In my opinion, previous methods of treating X. X is at a X. Patient has had the X. However, the patient has X. X meets the ODG criteria. The request for X.

X Medically Necessary

☐ Not Medically Necessary

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

XODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES