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Notice of Independent Review Decision

Amendment X

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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 with a history of injury on X. The mechanism of injury was X. The diagnosis was X On X, X was evaluated by X, MD for X ongoing complaints of X. Dr. X reported that the request for X had been denied. Clinically, X had X. The goal of the X was to confirm that the X. Also, to be X to try and provide X. The X showed X was X, X was X and X was X. On examination, X did have X. Therefore, X did have X. There was X of the X. There was X. There was X. The X was indicated as X, which were demonstrated by X.A X dated X showed X had been performed. X was in X. X was present. X was produced by X. The X was X. X was present. X was noted at X. X was present. X was present. An X dated X revealed X. There was X.Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Per the ODG by X site is conditionally recommended as a X. This treatment should be administered in X. X recommended for treatment of X. X are X. X at X is not recommended. X should be administered using X. X is not generally recommended. When required for X. The claimant reported X. On X examination, X was X. However, there was X. Furthermore, there was X. As such, the request for X: X is noncertified."On X, Dr. X wrote a letter of medical necessity for a X, "Guideline supports potential treatment with X. X demonstrates X. There is an X. Clinically, the patient has X. The goal of this X is to confirm that the X. Also, be X. On examination, the patient does X. Therefore, patient X."Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: "Guidelines only support potential treatment with X. Progress notes for this injured employee include complaints of X. However, X does X: X is not supported. Recommend non-certification."The requested a X is not medically necessary. The X dated X does not X. In addition, an X of the X dated X demonstrates a X. There is X. Furthermore, X is not indicated unless there is documentation of X. X with X with CPT codes: X is not medically necessary and non certified

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

The requested a X is not medically necessary. The X dated X does not demonstrate any evidence of X. In addition, an X dated X demonstrates a X. There is no evidence of a X. Furthermore, X is not indicated unless there is documentation of X. X with CPT codes: X is not medically necessary and non certified 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)**