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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

X have determined that X is not medically necessary for treatment of this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient's evaluation from X described X. This examination reported X and X. There were X. There was a reported X noted X. An X note reported that the Patient was able to do X and recommended that X would benefit from more X to X and X.

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

The Official Disability Guidelines & Treatment Guidelines (ODG) notes that in regard to X and X, "(1) X (X or injury to X that typically causes X and/or X or X in the part of the X from that X) must be well documented, along with objective X findings on X. X must be corroborated by advanced X studies (e.g., X) and, when appropriate, X, unless documented X support a X diagnosis. A request for the procedure in a patient with X requires additional documentation of recent symptom X associated with X. (2) X to conservative treatment (e.g., X)." ODG also notes that no more than X should be X using X.

The X indicated that in this case, the records provided for review reported X and X but did not grade the X or report other X that may X to a X of X. There are no reported X or X in X to the X noted. The X findings do not report X of any X at the noted X of requested procedure. ODG supports there should be X by imaging studies unless there is a clear X diagnosis based on X. The medical records provided for review do not provide indication of X by X in X by imaging. The records do not support performance of X at X, for X. As such, the medical necessity of the requested X is not supported.

Therefore, X have determined that authorization and coverage for X is not medically necessary for treatment of this patient's condition.

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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES:**
EPIDURAL STEROID INJECTIONS AND LOW BACK

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION):**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**