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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:

☐ Overturned Disagree

☐ Partially Overturned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who was injured on X. X was X. The diagnosis was X. X, MD saw X on X. X complained of X. X reported X was only able to X of the X. The X was described as X. It was made worse by X. There were X. X was X. X had a X. On examination, X and X were X. X was X in X. X had X and X. A X was X. No X were noted in the X. On X, X felt about the same as the prior visit. The X was X. X was following the X that was X. On examination, X appeared in X. On X, X stated X felt X. The X was X and X. It was X by X and a X with X. X stated that X had been given X and X without any improvement. X was unchanged from the prior visit. X of the X on X demonstrated X and X and X; X; X; X were noted. Treatment to date included X. Per the adverse

determination letter dated X by X, MD, the request for X was denied. Rationale: "The request is not medically necessary or appropriate. The treating provider examination does not demonstrate any evidence of X. Furthermore, there is no documentation or submitted medical records that X has been completed. The X does demonstrate X at X. Given this information, the guidelines do not support the requested procedure. There appear to be no X that would supersede the recommended guidelines. Therefore, the request for X at X, X and X is non-authorized." Per the adverse determination letter dated X by X, MD, the request for X was denied. Rationale, "Official Disability Guidelines (ODG) by MCG, X, necessitates documentation of no more than X prior to X for patients with X that is X. There should be documentation of X (including X) prior to the procedure for at least X. No more than X are recommended per session and the use of X (including other agents such as X) may be grounds to X the results of X and should only be given in cases of X. X should not be performed in patients expected to undergo a X and should not be performed in patients who have had a previous X at the X. Within the medical information available for review, there is documentation of a request for X. Additionally, the X progress report identifies a previous adverse determination due to unknown reasons. Also, there is evidence of a X. Furthermore, the X progress report identifies that the patient has X that is X with X and no X in the X of the X on X. Moreover, there is documentation that X is being considered. The request is medically necessary. Therefore, the request for X is non-authorized."

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

After reviewing the medical records, X agree with the denial for X, as there are insufficient findings to consider this X. Per ODG, this procedure is considered an option for X. Per the X progress report identifies that the patient has X that is X with X and no deficits in the X of the X on X.

Given the documentation available, the requested service(s) is considered not medically necessary.

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