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Notice of Independent Review Decision

Review Outcome

Description of the service or services in dispute:
X

Description of the qualifications for each physician or other health care provider who reviewed the decision:
X

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

X

Information Provided to the IRO for Review
X

Patient Clinical History (Summary)
X is a X who was injured on X. X was X. X was diagnosed with X.

X was seen by X, MD on X for complaints of X. The symptoms X in the context of an X at X on X. The problem was present for X. The symptoms were X. They were X. The quality of X was X. The X of the symptoms was X at the time of the visit and X on a X day. The X was X. X had been treated with X. The X was X. On examination of the X. X was noted to be X on the X. There was X noted in the X. The X was X. There was X and X noted. The X of the X was X.

An X of the X dated X demonstrated X. The X also X. Treatment to date included X and X.
An Adverse Determination Letter dated X and amended on X indicated the request for X at the X and X was non-authorized. The rationale was as follows: “Per ODG X guidelines regarding criteria for X, "X must be well documented, along with X on X. X must be corroborated by X and when appropriate, X, unless documented X. A request for the procedure in a patient with X requires additional documentation of recent symptom X associated with X." In this case, there is no documented evidence of X. Furthermore, it is unclear why X would be needed to treat X symptoms, or why X would be needed in addition to X at X. The request is not shown to be medically necessary. Therefore, the request for X at X and X is non-authorized.” Per an addendum dated X, a successful peer-to-peer call with Dr. X was made. Dr. X stated the X was requested in error and that the request was intended to be X and X (ie. X) X only. X noted the X between X on X and X findings on X. X confirmed that the X findings on exam were in fact on the X. There was X between the X findings and X findings. There was no change to the determination.
An Adverse Determination Letter dated X indicated the reconsideration request for X was not medically necessary. The rationale was as follows: “The request is not medically necessary. This would comprise of X at one time. The guidelines do not support this request. Furthermore, it appears that the X and the medical records reflect only X. There is no rationale for a X. There appears to be X that would supersede the recommended guidelines. 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.

Based on the clinical information provided, the request for X: X, X and/or X, X: X, X and X, and X: X is not recommended as medically necessary and the previous non-certifications are upheld. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There do not appear to be any X findings on X or X. Guidelines note that X is not routinely recommended for determining X placement during a procedure such as X. Also, it is unclear what X the patient has received for the X. It appears that prior X were directed at X.

Therefore, medical necessity is not established in accordance with current evidence based guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation
- ☐ Policies and 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 and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)