MEDRX

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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

The reviewer agrees with the previous adverse determination regarding the medical necessity of: X

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a X who sustained an injury on X, and is seeking authorization for X. A review of the medical records indicates that the X is undergoing treatment for X.

Progress report dated X has X with complaints of X. X reports X. Overall, X. X reports X. The X is X with X and X with X. Exam reveals X. X is X to X. There is X over the X over the X which is the X. X is X. X ordered and reviewed are noted to show X. Treatment plan included X.

Adverse Determination dated X was a denial for the requested X. Rationale states the information provided for review did not verify that the patient's X was attributed to X, and X was being recommended X of the X as well as X and X, use of X, X as X, with the indication that the patient will consider options and let the physician know. Records did not verify that the patient wanted to proceed with X or that X had X discussed at X prior visit. In addition, there was no indication that the X is X the patient's X the X and X. As such, the request is non-certified.

Appeal Determination Denial dated X was a denial for the requested X. Rationale states in the clinical record submitted for review, there was X documentation that revealed X. Objective exam findings revealed X. There was X to X over the X over the X. However, there was a lack of documentation of the indications for X. There was no documentation of X. Therefore, the request for X.

Prospective Review Response dated X maintains its position that the proposed treatment is not medically reasonable and necessary for the treatment of the compensable injury. X in the X and X is not recommended. The exceptions would be for X. In the clinical record submitted for review, there was X documentation that revealed X. Therefore, based on the reviewed documentation, the medical necessity for the proposed treatment in a patient where there is X, is not substantiated at this time.

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

As per ODG, “Not recommended for X. Not recommended solely to protect against X, X, or X. X is also not recommended following X or to X at X. X is appropriate for some situations where X may not be involved. X a X following X or X must eventually be X so that the X can X (eg, X across a X to X an X, or X following X).”

This X is seeking authorization for X from X. X presented on X with complaints of X. X underwent X in X. Overall, X. X reports a X of X developing over the X. The X is X with X and X with X. Exam reveals X on the X. X is X to X. There is X over the X over the X which is the location of the X. X is X. X ordered and reviewed are noted to show X. Detailed documentation is not evident regarding a X and X of recent, reasonable and X. This is evidenced by the treatment plan noted on X. X was recommended to trial X as X, X of X, X and X, and X as needed. The provided documentation does not confirm any of these treatment recommendations have been completed. Additionally, the X fail to demonstrate any X. The ODG Guideline criteria have not been met. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines. Therefore, the request for X is not medically reasonable or 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**

☐ **AHCPR- 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

☐ 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)