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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

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]:

The patient is a X who was injured on X, when the patient X. The patient

suffered X.

From X, to X, the patient was seen by X, LCSW. The patient presented to X on X, status X for X for X when the patient presented X. The patient was X and placed on X. X was X and X. X did not recommend any X. X showed X with a X in X. X were later discontinued. Per X, they recommended the following X - X. X was X on X. The patient was started on X for X. X had confirmed X in the X and X and was recommended to start X and follow-up with Dr. X in the clinic; X held and X continued. Prior to the event, the patient suffered X with X. X was X on X, for X and X on X. Upon authorization for the services, X initiated X on X, of up to X to include the following disciplines: X. The patient had been physically present for all scheduled X. Compliance had been X due to reports of X or X. However, the patient was demonstrating X with X, had shown X, and was willing to X on X, where the patient demonstrated X. X demonstrated X into the X. X was X which made X, particularly as X and was X as a result. This created X and a sense of X from the activities. X were transitioning to X to assist with X. The patient also self-reported feeling X and X, given the state of the X and the X. X was seen as X to the full participation in X, as well as a possible contributor to X. The patient was interested in addressing this with X, who was requested to be added to the team of treating disciplines. During the X on X, the patient expressed interest in X and learning how to X (X) in order that the patient could resume X with X, a favorite pastime of X. Upon learning that the X could do both things, the patient expressed X. A schedule for the upcoming report period was reviewed and approved by the patient. However, upon X arriving later that same day, the patient X, stating that X was willing to participate in X (X had already had X in the X). This X had agreed to the request and would proceed with X, with the hopes of extending X and X as the X and X builds and as the patient developed X with the X. Progress summary current level of X allowed the patient to remain X, where X received X and X by X. X worked X and was additionally present in the X in the X and on the X. The patient X without X but demonstrated X with X. At initial evaluation, the patient was able to X. X was X, with X. X was able to X with X and with support from X. X required X. There were X, particularly in the X, that caused to X. During the X, the patient had progressed to X, but continued to need to X, with X. X had demonstrated X and to remain X during X (as opposed to the X). X was now able to X, though with X and X. Due to X, the X could not be reassessed. There had been no carryover of the established X, with a plan for further X and X to be provided. Education had been

provided on X and X. At initial evaluation, the patient's participation in X was X, due to X and X. The patient was now increasing the amount of time X could X, which had allowed to engage in various small tasks around the X, such as X. X had not yet begun to X, though X had reportedly X. This would be a focus of the upcoming treatment period. The X and X managed the X; this was not a goal of the X. X managed all the X. This was not a goal of the X. The patient remained X and X. The X provided X in X to all X. The patient had participated in X with X during the X, where X demonstrated X and X and X. X required X for X. At initial evaluation, X completed X, X and was able to X. X required X for initiation of X and X and X for X necessary to X. The patient was able to X. There were X in terms of X and was X. The patient was now able to X. X completed X. X was now able to X. X benefitted from X and X and was now able to X. X benefits from X and X for consistent X. X was now able to X. X benefitted from X. X had recommended the use of X for X. However, the patient required X for the X. There was self-reported feeling of X and X, given the state of the X and X. The patient had, at times, X or completely X. X continued to stress to engage in only X. There were reported high levels of X that resulted in X. The patient and X confirmed that the X was aware of the situation and had been given X believed to be appropriate for the situation. There was evident X potential to achieve the projected outcomes with continued X. The X from X was X. The current plan was to remain X. X had been identified as X and would receive ongoing education and training to provide the recommended X. X date and plan were evaluated throughout X and subject to change. Timely notice would be given to the patient, X and Dr. X regarding any changes in X. Based on the X potential and rate of progress under currently X services, X for an X was recommended, to include X.

On X, an X from X indicated the patient's current progress/status. The patient was able to X but needed to X; X. X in the X had prevented the goal to increase X to X and X by X from being addressed at this time. The patient was improving the X. X was X with provided X. X was now able to X. X was able to X. X currently completed X related to categories of interest with X given X for X. X benefitted from X. X was able to X. X benefited from X. X had instructed the patient on a recommendation for the use of X for X. However, the patient required X. X was able to X. X benefitted from X and X for X. X was able to X. The patient was making gains in terms of insight into X and X. X was showing progress in X, X, and X when presented with X. X was able to X.

Per Utilization Review dated X, by X, M.D., the request for X was denied on the basis of the following rationale: "*A request is submitted for X. The date of injury is listed as X. A medical document dated X, indicated that a past X of the X disclosed findings consistent with the presence of what was described as X. There was documentation of X. It is documented that on the date of injury, the patient sustained X. The patient sustained X. There was documentation of X. Objectively, there was a documented X. There was documentation of an ability to X. There was documentation of an ability to X. Subjectively, there was documentation of X. Reportedly, previous treatment has included X. The submitted clinical documentation does not provide specifics to indicate what type of X have occurred with this form of treatment previously. Based upon the medical documentation presently available for review, presently, the medical necessity for this specific request as submitted is not established. At the present time, treatment in the form of X is not established. Recommend non-certification. Criteria: ODG X, X (X) for X Conditions, Last review/update date: X.*"

Per Reconsideration dated X, by X, D.O., the request for X was upheld on the basis of following rationale: "*Regarding the appeal for X. The Official Disability Guidelines states that the continuation of X is recommended when there are objective findings of X. Defined goals for the patient's interventions and plan duration should be specified. The previous request was denied as the medical provided for review did not provide data to indicate that there has been a previous X to treatment and there was documentation that reflected a concern as it related to X with regard to treatment in the form of X. In this case, the patient had participated in X since X. The patient was noted to have some X. Additional treatment was recommended. While it was noted that the patient had X at times, the patient did X. The patient was motivated to address the symptoms. The patient was noted to have objective findings of X. Given the patient's progress and likelihood of ongoing improvement with the requested treatment, continuation of the treatment was recommended. However, the current request was for X. As it was unclear if the patient would meet their goals in X and state jurisdiction does not allow for modification of orders without a peer-to-peer discussion and agreement, the medical necessity of the treatment cannot be established. As such, the X is non-certified. Criteria: ODG X, X (X) for X Conditions, Last review/update date X. ODG BY MCG: X, X (X) for X Conditions, Last review/update date: X.*"

An undated correspondence from X served as an appeal to re-initiate beneficial and medically necessary services for the patient. The authorization request for X was denied. Dr. X made recommendations to meet ongoing rehabilitation needs through medically necessary X through the X because the patient had not returned to the X prior to X. Prior to this event, the patient was X and enjoyed X. The patient now had X to X within the X and required the use of X. The patient was able to X (X) with minimal setup and now required X. Additionally, the patient experienced X and X with X or X that was now X. Experiencing these difficulties resulted in X and resulting in X that previously served to X as needed due to the X caused by the injury. The patient presented with X that required X treatment. These deficits manifested themselves in X. To engage such a patient required a treatment commitment. The team worked diligently with the patient to establish a mutually agreed-upon routine that could address the needs and result in progress. The patient participated in X and in the last week of service prior to going on hold awaiting the authorization request, was goal-driven and motivated to X. The patient additionally began X with X, X, in which the patient both gave and received X. The patient was now focused on recovery and progress and understood having X and was motivated to address the X. X had reported that each day since placed on hold, the patient had asked if the X was coming back. X noted that the patient experienced X in the X and X a X on X, indicating X. The patient had X requiring X and was only able to X. The patient improved to X. The patient on X required X. However, the patient had X. Building X for X for X would allow the patient to X such as X so that the patient could more fully X. X upon admission, the patient was not taking part in any aspect of X or X. The patient improved to be able to X. The patient was only able to X. The patient required X to initiate X and now was able to X. On X, the patient presented with X in the areas of X. The patient was now showing progress in X. When presented with X problems in the X, the patient was able to X. The patient initially was X. The patient self-identified as experiencing X and reported how this was X. The patient was specifically asking for help to address to be X and X and X, in a way that the patient had not been able to prior to the injury. The patient had agreed to participate in X with the X. According to the X, this was the first time that the patient had been open to X. X had been crucial to the case in helping the X and the X through X issues and created a more structured environment to facilitate cooperation with X and X requests, and follow through with motivating activities that engage patient. They ensured X, X between patient,

X, X, X, and X to ensure X. The X was requesting X to address the needs. It was anticipated needing X to complete the course of treatment but acknowledged that it was reasonable to request X and re-assess the progress and continued medical necessity. X met individual patients' specific X needs by providing X and X. A meaningful change was facilitated by X. Creating strategies and structure within the X environment that patients and their support systems could continue long after X results in durable outcomes.

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

Based on the new records submitted by the X group improvement has been clearly documented and meets the criteria per ODG. The prior determinations appear to have been presented before the latest update from X and in my opinion the request for X is medically necessary. However, the request appears to be X with X window, which is excessive and a shorter time period of X should be considered followed by a reevaluation. Therefore, the request is partially overturned to allow X.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES