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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 at X on X, when X.

From X, through X, the patient was seen by X, Ph.D., for X for X.

On X, the patient was evaluated by X, M.D., X. Reportedly, X sustained X on X after X. Due to this, X complained of X. X was first seen by Dr. X in the clinic on X. X was seen for several issues to include X. X had X since last being evaluated related to X. X hit X resulting in X on the X. X had much improved after the X in X. X reported improvement with X overall. X had been X and X. X last X was on X. X took X for X. X had been attending X with Dr. X. X noted X. X completed X in X. On examination, the X and X was X. The X was X with X. There were X to the X. X had difficulty X with the X. X was significantly improved. The diagnoses were X. Treatment recommendations included X.

On X, the patient was seen by Dr. X, who performed X (X) of X. The diagnoses were X. Recommended resuming usual activities, continuing current X program and follow-up in X as needed.

On X, the patient was seen by X, M.D., to establish care for X. X was seen for several issues to include X. X reported that the X had X after X in X. X was X to use X for X. X had X last X on X to the X, X, X, X, and X, X, X, X, X and X. X reported overall improvement with the X. X had been X. X noted X and X. This made it hard for X to X. This improved after X for X. X had not seen a X yet. Examination revealed X. The diagnoses were X. Treatment recommendations included X.

On X, the patient was seen by Dr. X, who performed X. The diagnoses were X. Recommended resuming usual activities, continuing current X program and follow-up in X as needed.

On X, the patient was seen in follow-up by Dr. X on X, X. X reported X and that X was building up in the X of the X. X was X with X by a X after X ran out of X. X continued to have X. Examination revealed X. Treatment recommendations included X.

On X, the patient was seen by Dr. X, who performed X. The diagnoses were

X. Recommended resuming usual activities, continuing current X program and follow-up in X as needed. Recommended X. Discussed X and X.

From X, through X, the patient was seen by Dr. X, for X.

On X, a X (X) of the X was performed at X and interpreted by X, M.D. (The medical document was poorly scanned and largely illegible).

On X, the patient was seen by X, M.D., for complaints of X. X reported X in the X. The X affected X. X was X with X and X with anything. No change since being last evaluated. X and X were the X. Dr. X, X placed X on X and stated that X might need X. X noted X. X was scheduled for X. X was about to get X by Dr. X, but this was denied. On examination, X were noted. X had X (X) in X mainly towards the X. Able to X. The X were X in the X. The diagnoses were X. Treatment recommendations included X. Counseled on how to maintain and improve X. Discussed X and to X or X while on X or X. (The medical document was incomplete).

On X, the patient was seen in a follow-up by Dr. X for X and X. X reported X in the X with X into the X. X was X. On examination, X were noted. X had limited X in X mainly towards the X. Able to X. The X were X in the X. On X of the X, there were X. There was X and X and X due to X. X were present X. X was X. The diagnoses were X. Treatment recommendations included X. (The medical document was incomplete).

On X, the patient was seen in follow-up by Dr. X for X. X had received X for X between X and X. For the majority of the aforementioned X, the patient has had documented X from X. At times, X has had X to X. X last X for X was on X. Since X had been past due for X, X was again having X lasting the entire day. X had only been X due to daily continuous X. On examination, X was noted. Dr. X noted that the patient clearly benefited from X for X and would require X.

Per a Utilization Review dated X, from X, the request for X had been approved. The proposed date of service was X. Rationale: "*The date of injury is listed as X. The patient is documented to be a X. The request is for treatment in the form of X. A medical document dated X indicated that previous treatment did include treatment in the form of X for X at an interval of*

X from X and X. It was documented that this form of treatment subjectively, X symptoms from a X. It is documented that on the date of injury, X. There was a reported X with this event. Objectively, there was documentation of X. There was X. There was a documented diagnosis of X. It is documented that on X, X, and X treatment was provided in the form of X. A medical document dated X indicated that there was documentation of X. There was documentation of X notable for X. It was documented that objectively, there were X. Objectively, there was documentation of X and X. A medical document dated X indicated that objectively, there was an ability to X. There was documentation of objectively utilization of X. A medical document dated X past treatment did include access to treatment in the form of X. It was documented that X of the X obtained on X was described as X. A request is submitted for treatment in the form of X. The case was reviewed at length with Dr. X. The date of injury is listed as X. It is documented that previously, treatment was provided in the form of X. A medical document dated X indicated that this form of treatment subjectively, X from X. A medical document dated X indicated that objectively, there was documentation of X with X. There was a documented diagnosis of X. As documented above, the case was reviewed at length with the requesting physician. This physician reviewer has previously reviewed this specific case with the requesting physician. Since a previous review with the requesting physician, additional clinical documentation was submitted for review and additional clinical documentation was clarified by the requesting physician. Previous treatment in the form of X by approximately X for an extended time interval. Treatment in the form of X is provided as it relates to the management of X. In this particular case, after a lengthy review with the requesting physician, this specific request would appear reasonable and appropriate as it relates to the management of the described medical situation. The submitted clinical documentation does provide data to indicate that previously, there has been a significantly positive response on an extended basis from treatment in the form of X. Consequently, presently, after review with the requesting physician, in this particular case, treatment in the form of X would be supported as reasonable and appropriate. Recommend certification."

On X, the patient was seen by Dr. X who performed X. The diagnoses were X. Recommended application of X.

On X, a Medical Peer Review was completed by X, M.D. Dr. X opined that the patient's extensive treatment to include the current treatment had all been

related to the X occurred on X as stated in the brief summary. The ongoing medical treatment is reasonable and necessary for the compensable injury that occurred on X. This ongoing medical treatment included X. Documentations submitted support X treatments as related to the compensable injury. X would include X for the working diagnoses of X. The patient's current X include X. This X had X and was recommended to be continued as medically appropriate and necessary. X, this X was an X used to treat X. Notes indicated from multiple X that the patient was dealing with X issues related to the work-related injury occurred on X. X should be continued as medically appropriate and necessary. The X regimen listed at this time was the most beneficial for this patient from the notes submitted. Documentation submitted did not support additional X testing as reasonable and necessary for the compensable injury at this time. The only type of X reasonable and necessary for the compensable injury would be X. Documentation submitted did not support any X as reasonable and necessary at this time. Documentation submitted did support X or X. Documentation submitted did not support additional X treatment at this time. Documentation submitted did not support additional X. The patient would benefit from X to include X. From the information submitted from several X, it appeared that the patient's X symptoms were directly related to the X injury on X. Dr. X felt periodic office visits would be reasonable and necessary occurring X. There would probably never be an endpoint in which the patient would not need any medical treatment.

On X, the patient was seen in a follow-up by Dr. X for X. X last X for X was on X. X reported a decrease of X. X planned to receive X on X. Examination was limited due to X. Dr. X noted that the patient clearly benefited from X for X and would require X.

Per a Utilization Review dated X, from X, the request for X was denied. "CPT: X). The services or treatments described above were not medically necessary or appropriate. This meant that we do not approve these services or treatment. The UR Number for this request was X. Rationale: "*This case involves a X patient with a history of an occupational claim from X. The mechanism of injury was detailed as X. X has been diagnosed with X. X include X. On X, the patient was seen via telehealth for a follow-up. X has been utilizing X for X. X last X were performed on X. X does have documented X from X. X does have a planned X on X. The physical examination was limited. The physician indicated for the majority of the*

aforementioned X the patient has had documented X. When X does not receive X, X has X. X has failed conservative care with X. The request has been received for X. The clinical basis for denying these services or treatment: Regarding the requested X, the Official Disability Guidelines indicate there must be documentation that the patient has X. Additionally, there must be documentation that they have not responded to X and their frequency is reduced by the X when compared to pretreatment average. It is noted that this is to be discontinued if X days are X. The submitted documentation indicated X has X. The documentation does not detail at this time X is appropriate to receive additional X given it appears X has less than X. Additionally, the documentation does indicate X does X on average with X however, the documentation does not detail that this reduces X frequency by X. Therefore, given all of the above the requested CPT: X is not medically necessary and is non-certified."

Per an Appeal Request Denial dated X, from X, an appeal was received on X for the denial of X. It was determined that the request still did not meet medical necessity guidelines. The UR Number for this request was X and no additional information was required from you at this time. The request below had been reviewed by a Physician Advisor not involved in the initial review, X, M.D. It was deemed that the request for X was denied. Rationale: "*The patient is documented to be a X, with a date of injury is listed as X. It is documented that on the date of injury, the patient was X. A medical document dated X, indicated that on the date of injury, there was X with this event. It was documented that treatment in the form of X were provided on X. It was documented that this form of treatment was provided at approximately X. It was documented that, this form of treatment X. There was a documented diagnosis of X. There was documentation of a X. There was documentation of a past X history notable for X. A medical document dated X, indicated that subjectively, there were symptoms of X and what was described as X. A medical document dated X, indicated that objectively, there was documentation of X. It was documented that there was an ability to follow commands appropriately. A medical document dated X, indicated that on this date, treatment was provided in the form of a X. A medical document dated X, indicated that subjectively, there were symptoms of X. Subjectively, there were symptoms of X. Objectively, there was documentation of X. Objectively, there was documentation of an ability to follow commands appropriately. There was documentation of X. A medical document dated X, indicated that there was documentation of a medical condition of a history of*

X. Objectively, there was documentation of what was described as X. It was documented that on X, treatment was provided in the form of X. The request is for treatment in the form of X. A request is submitted for treatment in the form of X. The date of injury is listed as X. A medical document dated X, indicated that treatment in the form of X were provided on X. It was documented that, this procedure provided X. There was a documented diagnosis of X. There was documentation of a X medical condition/past medical history of X. A medical document dated X, indicated that objectively, there was documentation of X. There was documentation of an ability to follow commands appropriately. Based upon the medical documentation presently available for review, the above-noted reference would not support a medical necessity for this specific request as submitted. The submitted clinical documentation does not provide specifics with regard to the frequency of X. The submitted clinical documentation does not provide specifics to indicate the amount of a decrease that has occurred with frequency of X on a month basis. Consequently, per criteria set forth by the above-noted reference, medical necessity for this specific request as submitted is not established. Medical necessity for treatment in the form of X is not established."

On X, the patient was seen in a follow-up by Dr. X via telehealth for X. X was X on X. X reported X. Examination was limited due to telehealth visit. Dr. X noted that it was medically necessary for patient to receive X for X.

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

The patient is documented to be X, with a date of injury is listed as X. It is documented that on the date of injury, the patient was X. A medical document dated X, indicated that on the date of injury, there was X with this event.

A medical document dated X indicated that previous treatment did include treatment in the form of X for X at an interval of X. It was documented that this form of treatment subjectively, decreased X symptoms from a X.

Previous treatment in the form of X symptoms by approximately X an extended time interval.

X ODG for X: X is defined as X. (X, X) A X of X concluded that X A compared with X was associated with X but was not associated with X or X. (X) The X approved X (X) to prevent X in X patients with X. It is recommended as a X (since other X should have been attempted).

In my opinion, X agree with the reviewing physician that personally discussed the case with Dr. X and certified X. "Consequently, presently, after review with the requesting physician, in this particular case, treatment in the form of X would be supported as reasonable and appropriate. Recommend certification." Thus, X (CPT Code: X)is certified as medically necessary.

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

☒**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**