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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 whose date of injury is X. X. X dated X indicates that chief complaint is X. The patient has completed X to date. Office visit note dated X indicates that X has been in the X. X is to X and X to X. X show X. X dated X

indicates that X still reports X and X in the X. On exam X is X. Office visit note dated X indicates that X has X of X. X is still having some X along X. Repeat X show X to be X. No problems. Current X include X. Daily note dated X indicates this is the patient's X. X reports X from returning to work today. X is X.

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 is not recommended as medically necessary, and the previous denials are upheld. The initial request was non-certified noting that the Official Disability Guidelines state that X after the X of the X is recommended, medical treatment at X over X. In the clinical record submitted for review, there was documentation of X. There was documentation X had completed X, with continued X including X, yet X. The request for authorization was more than the guidelines recommended for X condition without a rationale as to why X would not suffice. The denial was upheld on appeal noting that the requested X are excessive and exceeds the guideline recommendation. There were no exceptional factors noted that would warrant exceeding the guideline recommendation. There was also no indication X was insufficient. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient has X to date. The request for X would exceed guidelines. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient has X and should be capable of continuing to improve X and X with X.

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

X MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES