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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 X. The patient complained of X.

On X, the patient was seen by X, for X. The onset of the X had been X, following X. X occurred in X. The X was described as X. X to the X. X aggravated the X. The relieving factors were X. The symptoms had been associated with X. X revealed X. Previous X had included X. X included X. Previous X had included X. There has been no previous X. There had been X. The patient had attempted and X including X. The patient had attempted X as well with X. The patient had been approved for X in the coming weeks. X with X rated at X and X rated at X. X was X. On exam, X was X and X was X. X were X. X was X. The X had X. The diagnoses were X. The patient had signed X for X and would have X. Plan was to proceed with X and X.

On X, a X report from X identified the X detected X.

On X, a X indicated the patient had reconsidered and had X. The patient reported to have had X from X. The patient contacted X and cancelled the X that was scheduled to be done on X.

On X, X report from X identified the X detected X.

On X, the patient was seen by X for X and X. X were discussed. On exam, the X had X. X elicited with X. Plan was to proceed with X and changed X.

On X, a X report from X identified the X detected X.

On X, the patient was seen by X for X. X rated at X and with X rated at X. Plan was to proceed with X and X.

On X, a X report from X identified the X detected X. The X was X for X.

On X, the patient was seen by X for X follow-up and X. X interfered with X. Plan was to X.

On X, a X report from X identified the X detected X.

On X, the patient was seen by X for X. The patient rated a X of X and X. The patient was X. Plan was to X with X and X.

On X, the patient was seen by X, for X. X described as X. X aggravated the symptoms. Symptoms were relieved by X. On exam, the X had X. The diagnosis was X. X was X into the X. X was X. The patient was placed on X.

On X, the patient was seen by X, for X. The patient described X. Symptoms were relieved by X. X was X into the X. Plan was to X.

On X, a X report from X identified the X detected X. The X was X.

On X, the patient was seen by X for X for X and X. The patient rated X at X and X at X. Plan was to X.

On X, the patient was seen by X for X. The patient reported X. The diagnoses were X. X was restarted.

On X, the patient was seen by X, for X. The problem was X. The patient felt the X was trying to X. The patient was requesting X. The diagnoses were X. X was X into the X. A referral to X was ordered.

On X, an X by X indicated the patient was X.

On X, the patient was seen by X for X. The patient was in X and wanted a X because the X dated X did not help. The diagnosis was X. X was X into the X. Plan was to take the X as X and X. The patient was placed on X.

On X, the patient was seen by X, for X. The patient had X that X. X ongoing for X. X rated X. X described as X. X showed X. The patient had tried and failed X. The patient had tried X with another X that sounded like X. The patient had tried and X. The patient took X with some improvement in X. X was performed. X was reviewed. X and X made X better. X made X. On exam, the X had X. X and X were X. The diagnoses were X. The patient had X complaints from X. The patient had tried and X. The patient had some benefit with X with X and X. Plan was to proceed with X to assist with X and

X.

Per Utilization Review dated X, the request for X was denied on the basis of following rationale: "*This case involves a X. The injury occurred on X. The reported mechanism of injury is X. The patient was diagnosed with X. X were noted. Subjective complaints include there is a complaint of X. X down the X. X is rated X. Objective findings include X. There was a X. X was X. The X dated X reveals X most prominent at X. There was X. Previous treatment has included X. There was an attempt at X. X have included X. The request is for X. The clinical basis for denying these services or treatment: The Official Disability Guidelines only support X if there is a direct correlation between symptoms, physical examination findings, and imaging studies. Although this injured patient complained of X, there are X noted on physical examination. Additionally, X does not reveal X to potentially support treatment with X. Accordingly, this request for X is not certified.*"

On X, the patient was seen by X. The patient continued to have X and X related to X. The patient had X. The patient had been doing X. The patient continued to require X and X for X. The patient was requesting X as X was becoming X. X at its X. X. X made X. X tried in the past and X were X. On exam, X had X. X and X were X. The diagnoses were X. Trial of X to better assist with X was recommended. X were X.

Per Reconsideration dated X, the request for X was upheld on the basis of following rationale: "*Principal Reason and Clinical Basis: This case involves a now X with a history of an X from X. The mechanism of injury is detailed as X. The current diagnoses are documented as X. X were not documented in the report. A X was completed on X for subjective complaints of X. Conservative treatments trialed include X. The patient has a history of X with X, as stated in the documentation. Per objective assessment, X. There was X and X. X was intact to X. Prior review dated X, denied the request for X. The reason for denial stated there were X noted in physical examination. Additionally, X does not reveal X. The appeal request is for X. Regarding the request for X. Official Disability Guidelines state X are recommended for short-term treatment of X. This treatment should administer in conjunction with X. Per subjective reporting, X was documented. Per objective assessment, there was X. However, there was no documentation of*

involvement in X. The purpose of X is to X and X in the short-term. An active treatment program is encouraged to facilitate X. A conversation was completed with X. During peer-to-peer conversation, it was discussed the patient has a history X but had a side effect of X that required a X. The patient also had X. However, X report was unavailable for review to verify X. Also, there was a lack of physical exam findings. Therefore, the request for X remains non-certified. Description of Source of Screening Criteria: ODG, X, X, Last review/update date: X, ODG by MCG X, Last review/update date: X."

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

Per Official Disability Guidelines, there must be objective findings of X on examination and X must be corroborated by imaging studies X. Presently, the imaging studies, X, do not show evidence of X that would account for the X subjective complaints. There is no indication that the claimant has undergone X and therefore given the lack of correlation between subjective reports and objective findings on physical examination the requested X cannot be supported as medically necessary and the prior utilization review determinations are upheld. Therefore, the request for X remains noncertified.

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

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