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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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X. X was X. The diagnosis was X. X was seen by X on X for a follow-up of X, which was rated X. X had been seen on X in X and was diagnosed with X. X was treated with X at that time. X stated overall X symptoms had X. X had X. X had X. X and X had X. X and X was X in the X to the X. The X had X. On examination, X was X. X was noted to be in X. X was X. Examination of the X showed X. X along the X had X. X had X. X was X, X was X, and X was X. Examination of the X showed X. The X in the X. X was X. X in the X was noted to be X on X. X was noted to be X. X of the X dated X was X for X or X. X was completed by X on X. X demonstrated X did not meet the required X of X including X. X presented with X. Overall test findings in combination with clinical observations, suggested the presence of X. Overall test findings in combination with clinical

observations, identified X. Based on the examination, X demonstrated X was not capable of X. X required X. X had a current X. X still presented with a X. X was completed by X on X. X reported symptoms and findings included X. X verbalized X had X with the X since X. X examination revealed X. X appeared X. X had been undergoing X. X demonstrated X about X and X. X demonstrated X when X. X were X. X with X were noted. X appeared to be X. X presented with X. X was rated X. X had X, with evidence of X, which persisted X. X had been in X since X, without X. X was X on X. Due to X, X had not X. X reported X. X reported X. The diagnosis was X. X did not have a history of X before the injury occurred. Since the injury, X reported X. X had participated in X including X. X was motivated to participate in the X with the intention that would assist X in X. Examination of the X dated X included X. The X was X, X, X was X and X was X. X elicited X to the X. The X of the X was X. X was X. X of X and X demonstrated X. X revealed X to the X. A X on the X was noted. X and X were each X on the X. The X was X indicating X and X was X, indicating X. The X was X and X was X. The X included X. X was noted to be X for X. Based on X, it did not appear that X would benefit from X. X could not reach a X unless X in both X and X. Treatment would be more successful when X and X were X. X could provide X in reference to these X. X, such as those provided in X were beneficial to X because it provided X. X to address the X in X, which X was experiencing. A X addressed these issues with X. X appeared to continue to X. X had participated in X and had been ruled out for any additional X. X had been X and did not appear to be X from X at the time. X identified problems included X. X would X. It would X from X to X. It would X. It would X. X was X. X position required X to X. Post injury, X had been X. X reported X essential X consisted of X. X stated X was X. During initial interview, X was observed having difficulty with X. X required X to be X. X was concerned X. Prior to this injury, X was able to X. X maintained X. X was concerned X would X. X was motivated to X and X. X also demonstrated eagerness to participate in X to identify X. X expressed readiness to consider X. X was receptive to X. X overall clinical impression indicated X was able to X. X was elevated due to X but X was not experiencing X that would interfere with the X. X had participated in conservative treatment. Treatment team would X. X would X with the X and X such as X. X would participate in a X. Initial request for services in X was for X. After X completed X, a Treatment Plan Review was completed and submitted to demonstrate evidence of compliance and significant subjective and objective gain. Under the X, X was provided from the X were

completed. X simply addressed X and did not address X. X needed X such as our X to improve X. All of these facts listed above demonstrated X. The X would improve X. It would X to improve X. X current X would be X to a X. At X, a goal of X, X would be X. X would X on X to a X. X would X to X. X would X from X to X. X would X and X and X and X from X to X. The effort would be X by X. X would be provided with X to X to return to X. X of the X dated X revealed X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, the request for X was not medically necessary or appropriate and was denied (noncertified). Rationale: "In this case, X. X, consistent with X. The patient may be a X for the proposed program on the basis of this information. The clinical basis for denying these services or treatment: The Official Disability Guidelines state that X is considered to be X as well as X. The medical records do not establish the medical necessity of the requested X. According to the X progress note, the patient's X is listed as X. This does not suggest that the patient would require X. Moreover, X of X is considered to be X as well as X. In this case, the X, consistent with X. The X is X, consistent with X. The patient appears to be X for the proposed X on the basis of such information. Therefore, my recommendation is to NON-CERTIFY the request for X."A letter was documented by X on X indicating X was the requesting X for the X for X. Although a peer was attempted, the peer reviewer contacted X, the referring X. It was essential that X be given the opportunity to perform the peer review for the services requested. Per a reconsideration utilization review adverse determination letter dated X by X, the request for X was not medically necessary or appropriate and was denied (noncertified). Rationale: "In this case, X, consistent with X. X is X, consistent with X. The patient may be X for the proposed X on the basis of this information. The clinical basis for denying these services or treatment: The Official Disability Guidelines state that X is considered to be a X as well as X. An appeal has been requested for X. Peer review performed on X, non-certified the request for X. It was noted that the patient's work status was listed as X, which did not suggest that the patient would require X. Moreover, X are considered to be X as well as X. In this case, the X, consistent with X. The X was X, consistent with X. The patient appeared to be X for the X on the basis of such information. A letter of appeal dated X, was submitted for review. They are requesting a peer to peer discussion. No additional clinical information was submitted for this review. During the peer to peer discussion, the patient attempted to X right after X but was X. The patient since has completed X and

according to the latest X remains at X. The patient's X requires X to be at X. X also added that the patient is on no X as of now even though X suffers from X. X also added that the patient is not being treated by any other providers. X added that the patient would be put on X once X enters the X. No additional clinical information was exchanged. Given the X and this patient's current clinical profile, the above request does not have medical necessity. The patient has not been X. Moreover, the patient suffers from X which are disqualifying criterion for X. As noted by the prior reviewer, X is considered to be X of X as well as X. X performed on X found X, consistent with X, and X of X, consistent with X. These X would render the patient X for this type of X. Therefore, my recommendation is to NON-CERTIFY the appeal for 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. There is insufficient information to support a change in determination. The submitted clinical records indicate that the patient has been determined to have reached X. X dated X indicates that the patient reached X on X for X. The patient's only current X is X. There is no documentation of any recent active treatment modalities. The patient presents with X and X; however, there is no documentation of X.

Therefore, medical necessity is not established in accordance with current evidence based guidelines for the request of X.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL