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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 with a date of injury X. The mechanism of the injury was noted as X. The assessment included X. X was evaluated by X on X for a follow-up of X. X requested X at the time. X complained of X. The X to X. The X was described as X. It was rated at X. The X occurred at X, with X and X, when X, and when X. The exacerbating factors included X. The symptoms were X by X. Associated symptoms consisted of X. On examination of the X, X was X. The X and X were X due to X and X. There was X and X at the X from X through X. X and X were appropriate. The assessment included X. Treatment to date included X. On X, X wrote a letter for medical necessity for X. It was documented that "X that has lasted well beyond X could not be X with X. X has tried X, that did not help. The patient has X to respond to X in X, which is not adequately X and X. X is on X. X has

tried X in the past with X but gained X over time that led to needing more X to control the X. This led to X for X, and decision was made to X. X is off X. X would be able to controlled exclusively by our office. The patient underwent X in X and X in X to X; however, X continues to have X. X has X in the X with X. X has had imaging that would correlate with this. X has X over X and X. The patient does not have any existing X and has received X. Further X is likely not to X. At this point, X strongly feel that the patient is a good candidate for X. With X being off X for some time, a X could work very successfully for the patient. X feel this is the most appropriate treatment. The procedure is reasonable and medically necessary".
Per a Utilization Review decision letter dated X, the request for X was denied by X. Rationale: "Regarding the requested X, official disability guidelines (ODG) states that X may only be utilized as X treatment for those with X or X of the X or X. They may also be utilized for X after the X to treat with X. In this case, there was a prior denial as the X evaluation was X. Additional information demonstrates the claimant with X. The provider indicates there are no X. However, the documentation does not substantiate X in this clinical scenario. There is no clear indication there has been documented X in X and X in response to X, but X preclude their continued use. Overall, this request for X is not medically necessary". Per an Adverse Determination letter dated X, the prior denial was upheld by X. Rationale: "Official Disability Guidelines states that X for X are recommended only as X treatment alternative for select patient. The progress not indicated that the claimant had X and X. The claimant reported X occurs with X or when X, was relieved with X and X. The claimant is also able to do X. On physical examination, there was X to the X, with X and X to the X. There is no documented evidence of extenuating circumstances to support the use of X. As the request for X is non-certified".

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for X was reviewed. X would agree with the pervious determinations that medical necessity is not established for this treatment. X for X are recommended only as a X alternative for very select patients for whom no other treatment has provided benefit. While the records note the claimant has X and X, the claimant is able to do X, supporting X is X. Examinations note X to the X, with X and X, but no more X. Given the documentation available, the requested

service for X is considered not medically necessary.

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