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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. The exact mechanism of injury (MOI) was not provided. The patient was diagnosed with a X of the X and X.

About X after the X, on X, the patient was seen by X, X, at X and X in a X progress note for pain in the X. The X was documented as X. The patient had a X with X in X. The patient had X and was not able to X at the X. X was doing well with other X at the X. X did not have X. X was a X and needed to X and X with X. X was not X. X reported in order to X, X had to be able to X and X and needed to be able to X and X. The X level rated at X at X and X at best and current. Previous findings as of X, pain level rated at X at X and X at best and current. Pain described as X/X. The X factor was any X. X had made X in the X and would benefit from continued X. X continued to need more X in order to be able to X. X was X. X problems included X, X, X, X of X due to X due to X and X. The treatment diagnoses were pain in the X and X. Treatment plan was to continue X and X. The treatment plan was certified medically necessary by X, X.

On X, the patient was seen by X, X, M.D., for evaluation of the X. The patient was status X and X (X and X) with X for X and X of the X as well as closed treatment of X. The patient continued X and noticed X in X. This continued to prevent X from returning X as X did require X, but X was X so X and X had been helping. On exam, X had X with X of X as well as the X. There was X. There was no X to X over the X. There was X to the X with X, X, X to X, and X and X. There was X. There was X to all the X. X was X, X, X as well as X and X of the X. X were obtained and X to X and in X. The diagnoses were X with X, X and X. X was instructed to X. No X was necessary. X was to take X and/or X. Dr. X recommended to continue and complete X as X had been making improvement. Possibility of X in the future if X did not improve with X and X was discussed. X order sent auth to Workmen Compensation. X was to continue to X on X and X and X to help with the X.

On X, a Peer Review by X, M.D., indicated the request for X was not medically necessary. Rationale: "*The patient was X. The mechanism occurred after a X. X has been treated with X. The file is requesting X. There are no provider notes available; X. The medical treatment guidelines support up to X over X for treatment of X and upper X. In that the patient is X, had X and there are no recent provider notes providing a rationale for ongoing X, the request is not supported. Therefore, the request for X is not medically necessary.*"

Per Utilization Review dated X, the request for X for X was denied on the

basis of following rationale: "*After peer review of the medical information presented and/or discussion with a contracted Physician Advisor and the medical provider, it has been determined that the health care service(s) does not meet established standards of medical necessity. This review applies only to the specific service(s) listed below. Any additional service(s) will require a separate review process. Specific Request: X, X certified by Physician Advisor. Physician Advisor Decision Date: X. The above review was made based on guidelines which are developed from acceptable standards of practice as recommended by medical specialty societies, the latest evidence from published research, federal agencies and guidelines from prominent national X and X.*"

On X, a Peer Review by X, M.D., indicated the X was not certified. The patient attended X as of X. The patient was doing well with X at the X. The patient had improved the X, but X was recommended. The patient needed more X to X the X. The patient continued with X and X were recommended. Clear documentation of the progress to date was not submitted. X had a X and the X was X of the X but with X. X had X. Rationale: "*The history and documentation do not objectively support the request for an X at this time. The ODG "recommends up to X" and outlier status has not been described. The patient has attended what should have X been a reasonable number of X and there is no clinical information that warrants the continuation of X for an extended period of time. There is no evidence that the patient is unable to complete the X with an independent home exercise program X. The medical necessity of this X has not clearly been demonstrated. Therefore, the request for appeal X is non-certified and upheld.*"

Per Reconsideration dated X, the request for appeal X was upheld on the basis of following rationale: "*Physician Advisor Decision Date: X. The above review was made based on guidelines which are developed from acceptable standards of practice as recommended by medical specialty societies, the latest evidence from published research, federal agencies, and guidelines from prominent national bodies and institutions.*"

On X, a X was completed by Dr. X.

On an unknown date, an Authorization Request from Day X and Wellness indicated X recommended X of start date X and end date of X for pain in the

X and X.

On an unknown date, an Authorization Request from Day X and Wellness indicated Dr. X recommended the patient to continue the X. The start date was X, and the end date was X. The CPT codes were X, X and X.

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

The 1st utilization review physician stated X reviewed X and no provider notes; thus, not enough information was available to certify the request for X and X.

The 2nd utilization review physician reviewed the X note and a provider note from X, finding no documentation of clinical improvement over time; thus, the request for X was noncertified.

X have reviewed the same information; no additional records have been made available for review.

The noncertification for X appears to have been appropriately formulated, primarily on the lack of stated clinical rationale. The claimant appears to have relatively X and a X. X are medically probably unlikely to produce substantial benefit based on the results of the X, alone. No clinical rationale has been produced by the provider or X by which to X ODG recommendations. Although up to X could have been authorized initially over the X, X at this late date are medically probably unlikely to produce substantial benefit.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES