CALIGRA MANAGEMENT, LLC
344 CANYON LAKE
GORDON, TX 76453
817-726-3015 (phone)
888-501-0299 (fax)

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 mechanism of injury was documented as a X.

On X, X, D.O., performed X. The X were X.

On X, the patient was seen by X, FNP-C, for X. The patient continued to report X. Pain was described as X. The patient was X. The patient noted that the X. X had to take X. The aggravating factors included X. X had X. X had X. On exam, the X was X. X level rated at X, and X level rated at X. X had X. X was X. X score showed X. The diagnoses were X. X was being treated with X. Plan was to X.

Per Utilization Review dated X, the request for X: "*There is a complaint of X. X symptoms are X. The X examination noted an X. There has been a previous X. Previous treatment had also included X. This previous X. X have included X. X have allowed a X. The patient was diagnosed with X. X include X. Criteria: ODG X. ODG by MCH (www.mcg.com/odg), Evidence-Based Medical Treatment Guidelines, X. X. Conditionally Recommended. Recommended as indicated below for carefully selected patients with X. X evidence, X. ODG Criteria: X. The most recent progress note provided for review dated X does X. Absent these objective findings, this request for a X.*"

On X, an Expedited Appeal Request from X was documented in reference to the denial received for an authorization request. This authorization was denied due to X. The requested information for review was enclosed. Request to consider these services authorization approval was made.

Per Reconsideration dated X, the request for X: "*Service being appealed: X. Determination date: X. URA #:X. Reason for non-certification: At your request, X have reviewed the medical records pertaining to the above-captioned patient, at which time a preauthorization review was performed for medical necessity. History: This case involves a X with a history of an occupational claim for X. The mechanism of injury was documented as a X. The request is for X. The diagnoses were documented as X. X included X. Per the progress note dated X, the patient reported X. On X examination, the patient X. There was X. Previous treatment included X. The prior X. The prior review dated X noncertified the requested X. Criteria: ODG X. Recommended as indicated below for carefully selected patients with X. ODG Criteria: Criteria for X. Conclusion: The ODG by X. Conflicting*

evidence, primarily X. The patient reported X. On X examination, the patient X. There was X. However, there was X. As such, the request for X."

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

ODG Criteria

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