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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]:
The patient is a X who was injured on X, when X had a X.

On X, the patient was seen at X by X, X, for an X evaluation for X. X had a X. X was taken by X. X was X. X was X. X was X. X scale was X. On examination, there was a X. The X was X. There was an X. Modified X was X. The diagnoses were X. The plan was X.

On X, Correspondence from X was documented, indicating the request for X.

From X, through X, the patient attended X.

On X, X recertification from X was performed. The patient noted X. X was X. X was X. X had X. X was requesting a X. The X scale was X. On exam, X. There was X. There was X. X test was X. The X was X. The plan was X.

On X, correspondence from X was documented, requesting authorization for X.

On X, adverse determination from X was documented, indicating X. Rationale, *"The clinical basis for denying these services or treatment: A request is submitted for treatment in the form of X. The claimant is documented to be X. The date of injury is listed as X. A medical document dated X, indicated that there was a documented diagnosis of X. Subjectively, there were symptoms of what was described as X. X was described as a X. There was documentation of a X. Objectively, there was documentation of an X. Reportedly, previous treatment has included X. Based upon the medical documentation presently available for review, the above-noted reference X. As documented in the summary, previous treatment has included access to X. The above noted X. As a result, presently, X."*

On X, correspondence from X was documented, requesting authorization for X.

On X, Correspondence from X was documented, indicating requested X. Rationale: "*It was determined that the request X. The rationale used in making the determination X."*

On X, an Appeal Letter by X, X was documented. It stated, "The patient would benefit from X. The patient was being X. However, X was X. The patient was also X. This was X. X is X. The patient X. This was not X. The patient was compliant with X. Currently, the patient is now X. It is now my professional opinion that X would require X. X, the X attempted in X. X never X. The only calls X. I do X. On one occasion, X. X return X. X also X. The only visits the patient X. X never X.

On X, Correspondence from X was documented, indicating a X. The diagnoses were X.

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

X have reviewed the medical records and the diagnoses of X. Subjectively, there were X. The request is for X. The individual has X. Last exam revealed X. Per ODG a X. The medical services requested X.

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