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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]: X is a X who was injured on X. While X, the X of X was X and X sustained X, X, X, and X. The diagnosis was X; X of X, X and X; X; X and X with X; X; X due to X; X; and X. On X, X was seen by X, MD for a follow-up for X and X. X rated pain at X. X had X so far. X stated X after the X. X reported the X for about a X. X presented to the office to see what other options X had. On examination, X was X, X, and X. There was X and X with X / X. X test was X on the X. There was X / X and X noted. X / X was seen. The assessment was X, X of X and X, X, X and X, X with pain, X, X due to X, X of X, and X. It was opined that X had X but X after X. X had X, and X. Ongoing X and X prevented X from returning to X. The X were X and would require X. X and X were prescribed. The plan was X. If X, X may benefit from X and X. X was recommended. X was evaluated by X, PT

on X. A thorough X was completed. X did report that X had X in X. X did not have any X and did not want to have any. X also reported X had X for X, which included X, X, and X. X reported a X was recommended by X physician to manage X pain but insurance approval was denied. X had been X since date of injury. X was X. X was recommended X. On examination, X was X, X, and X. At the time, X was rated at X, X, and X. Pain was X by X and X, X, and X. X at the X on X was X, X, X and X. There was X and X. X showed X, X, X and X was X. X was seen at X. X and X. X was recommended X. An X dated X showed X with X of the X and X. An X indicated X likely X. There was no X to suggest X. X of the X was X. Treatment to date included X, X, X, X, X, X, and X. Per a utilization review adverse determination letter dated X by X, MD, the request for X, X, X was denied. Rationale: “The requested X for X for the X per X order is not medically necessary. The requested X is not indicted because based on the record, the claimant has undergone X, but the X, X response etc. was not provided. As per the ODG guidelines, X may be necessary for X. The X the claimant has X and X response should be provided to determine whether X is a candidate for the requested X. There were X noted that would warrant exceeding the guideline recommendation and X. Recommend non-certification of the request for X for X order.”Per a reconsideration review dated X by X, DO, X, X, X was denied. Rationale: “Based on the clinical information provided, the appeal request for X for the X per X order is not recommended as medically necessary. The initial request was non-certified noting that, “The requested X is not indicted because based on the record, the claimant has X, but the X, X response etc. was not provided. As per the ODG guidelines, X may be necessary for individuals with a X. The X the claimant has X and X response should be provided to determine whether X is a candidate for the requested X. There were no X noted that would warrant exceeding the guideline recommendation and X. Recommend non-certification of the request for X." There is insufficient information to support a change in determination, and the previous non-certification is upheld. In regard to treatment for the X, there is X completed to date or the claimant's response thereto submitted for review. There is no information provided regarding X completed to date specifically for the X including X, dates of X and claimant's response. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. Recommend non-certification of the request for X.”X reviewed the provided documents. X suffered X due to an X. X recent X and X support this X. X would be

appropriate in this case. However, there is a confusion in the provided document whether X has already received X before the request per X order. X would recommend the provider providing clarification on prior history of X including the date of treatment, the X, and X response. X would recommend certifying the request if the patient has X other than an evaluation by a X. Therefore X recommend that the requested X, X, X be X, X, X certified for medical necessity.

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

X reviewed the provided documents. X suffered X due to an X on X. X recent X and X this diagnosis. X would be appropriate in this case. However, there is a confusion in the provided document whether X has already X before the request per X order. X would recommend the provider providing clarification on prior history of X including the date of treatment, the X, and X response. X would recommend certifying the request if the patient has never received X other than an evaluation by a X. Therefore X recommend that the requested X be partially overturned to approve X certified for medical necessity.

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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

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

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