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Notice of Independent Medical Review Decision

Reviewer's Report

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

Physician, board certified in X

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This case concerns a X who has requested X. The Carrier denied this request on the basis that these services are not medically necessary for treatment of the member's condition.

A review of the office note dated X indicated that the member was being seen for X. It noted that the member previously had an X which X. It indicated that the member was sent for X. It noted that the member reports continued pain at X. It indicated that physical examination shows X. It noted that X. It indicated that X. It noted that the member X. It indicated that X. It also revealed X. It noted that X. It indicated that X. The office note explained that based on the member's X, the option of was discussed and the member opted to X.

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

The Maximus physician consultant explained that X. The examination revealed X. The treatment plan included X.

The Maximus physician consultant indicated that X.

The Maximus physician consultant noted X. The treatment plan included X.

The Maximus physician consultant indicated that X. The treatment plan X.

The Maximus physician consultant noted that X. The treatment plan included X.

The Maximus physician consultant indicated that X.

The Maximus physician consultant noted that the member was being treated for X. The documentation does not support ongoing X treatments. ODG guideline criteria have not been met as X. There is no X to support the medical necessity of this request as X. Therefore, the requested X for X is not medically necessary for treatment of the member's condition.

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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES.**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES:**
ELBOW CHAPTER, SURGERY FOR EPICONDYLITIS, ELBOW CONDITIONS

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

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

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE**

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