Vanguard MedReview, Inc.
101 Ranch Hand Lane
Aledo, TX 76008
P 817-751-1632
F 817-632-2619

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X: MRI X interpreted by X, MD with X Diagnostic
X : Initial Pain Evaluation by X, D.O. with X Pain and Wellness
X: Follow up Note by X, D.O., P.A.
X: UR performed by X, D.O.
X: Follow up Note by X, D.O., P.A.
X: X Patient Screening by X Solutions
X: UR performed by X, D.O.
X: UR performed by X, MD.

PATIENT CLINICAL HISTORY [SUMMARY]:

X: MRI X interpreted by X, MD. **Impression:** 1. No MRI evidence of X or X. 2.X; No evidence of X. 3. X.

X: UR performed by X, D.O. **Rationale for Denial:** The request is non-authorized. X is not medically necessary. First, this X is not supported for use by ODG for either a X or X purpose due to a lack of medical research to verify its efficacy. Second, there is no x-ray or MRI of the X to indicate that X is an issue. Finally, X is not required with this nor is it standard of care.

X: UR performed by X, MD. **Rationale for Denial:** A X is not medically necessary. Guidelines do not recommend X for X. Current research is minimal in terms of trials of any sort that support the use of X. Documentation does

not support the listed diagnosis of X conditions. Therefore, the request for a X is not medically necessary and appropriate at this time.

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

Based on the records submitted and peer-reviewed guidelines, X is not medically necessary. Guidelines do not recommend X. Current research is minimal in terms of trials of any sort that support the use of X. Documentation does not support the listed diagnosis of X conditions. Therefore, the request for a X is not medically necessary and appropriate at this time and this request is non-certified.

Per ODG: XX

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**

☐ **AHCPR- 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**

☐ **PRESSLEY 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)**