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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:

X

I have determined that the requested X is not medically necessary for treatment of this patient's condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The X who has X.

On a X, the claims administrator X. The claims administrator stated that the X. On a prior X, the claims administrator X. It was stated that the X. The claims administrator X.

A X was reviewed and was notable for X. X was notable for X.

On a X it was stated that the X. The X. The X went on to X. The X. It was stated that the X. Continued X.

At an encounter on X. Continued treatment through the X. The X. The X. The X following introduction of X. The treating provider stated that it was X. The X was X. The X. The X was reportedly X. The X. The X was described as having X. The X was given a X.

On X, the X was given X. X were X. The treating provider acknowledged that the X. The X was X. The X had received X. X medication list included X.

On X, the attending provider X. The X was X. The X continued to report X. The X exhibited X.

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

The request in question was framed as a request for continuation of X. ODG's X notes that X. Here, the requesting provider's documentation submitted for X. ODG further X. ODG notes that continued treatment through such a program should be contingent on evidence of X. However, based on the information provided for review, it was unclear why the X. The X. The records provided for review X. Therefore, the request is not medically necessary.

Therefore**,** I have determined that authorization and coverage for X is not medically necessary for the treatment of the patient's medical 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**

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

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

☐ **TMF SCREENING CRITERIA MANUAL**

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

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