Health Decisions, Inc.
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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:
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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a X. At the time of the accident X was X. X fractured X radius. X received X. X participated in X. X has been on X. X had an e X. There is also a question of X.
X Follow-Up with X, MD. X is X. X has X. Current Medications: X. X has a X. X does have some X. Impression: X.

X: MRI X. Impression: 1. X
X: X-ray X. Impression: X was not obtained.

X: X-ray X. Impression: 1. X.

X: Progress Note X, DO. States X. X
. **Assessment:** 1. The X. 2. The X. 3. Patient was X. 4. The evaluee X. **Recommendations:** 1. The evaluee would X. This program may be necessary in order to improve the X. 2. The evaluee would benefit from a X.

X: Intake Update and X PhD. **Clinical Summary:** X endorsed having one or more X symptoms that are X and result in significant disruption of X. In addition, there were X. X state that pain X. The state has X. Information available indicated that X has X. X described X. X noted an X. X also X. These X. **Treatment Recommendation & Objectives:** We concur with X, MD's recommendation that X. Currently, X is X. X has X.

X: Request for X. Summary: Prior treatment X. X is approximately X. X pain is X. X has X. X describes X. X has X. X treating doctor has prescribed X as medically necessary. This X is needed to X.

X UR performed by X, MD. Rationale for Denial: Based on clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There was no documentation that the patient had X. No additional information could be obtained. Thus, the current request is not supported.

X: UR performed by X, MD. Rationale for Denial: Based on clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The records suggest this patient has X. It is noted by comparison that X. The patient has a X. The patient has X. There is no support for an X.

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

Determination: Denial of X since the request meets clinical and ODG criteria for medical necessity. A X. Records indicate X. There has been an X. The X plan includes X. Therefore, X is reasonable and medically necessary.

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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESLEY 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)