Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

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 patient was X. X of a X. X has also consistently followed-up with Dr. X for X. X was documented on X. X on that date X. The patient has also X. The patient has X. X and X. In fact, at the X. It has X. The patient's X, Dr. X. A X on X reviewed medical

records to that date, including a X. In that X, it was noted that the X. The patient X. Dr. X. Dr. X. On X. Dr. X followed-up with the X. X evaluated the patient on X. This evaluation was done after the patient X. On X was performed by X, who documented that the patient's X. Moreover, review of the X. Moreover, the X.

An X. Initial review by a X recommended denial of that request, X. The physician advisor discussed the case with the requesting X. An appeal for that denial was submitted by X. X did X. X also X. A X the denial on X. The X noted that X had X. Therefore, the X continued to recommend denial of the X.

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

It did X. Additionally, it does X. Furthermore, the patient X. Since the patient has X. I agree with both of the previous physician advisors and, therefore, also recommend denial of this request, upholding their previous decisions. The requesting provider has also documented that this patient has X. Therefore, the X is not appropriate, medically necessary, or in accordance with ODG and the previous adverse determinations should be upheld at this time.

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

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

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

X 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)