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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

The reviewer is a Medical Doctor who is board certified in X

REVIEW OUTCOME

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

X

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of X.

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a X with a X. The X. The current diagnosis is documented as X. X are noted to include X. The patient underwent an MRI of the X, which was noted to reveal X.

The patient was evaluated on X for X. X rated X pain a X. The patient reported that X pain was X. X also reported X. The physical examination noted X. The X was to proceed with a X due to the X and X results.

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

Official Disability Guidelines- X

Recommended on a case-by-case basis as a short-term treatment for X. X are not recommended. This treatment should be X and the X. X are not recommended as a treatment for X. While only X.

Patient X:
(1) X. X must be X. A request for a procedure in a patient with X.

(2) Initially X.

Note: The primary purpose of X is to X and X. There is no evidence that X.
(1) X should be administered using X. X guidance is not recommended.
(2) Additional X on evidence of X
(i) X is not recommended X.
(ii) X is not recommended.
(iii) X are not recommended for X
(iv) X can include X
(v) All patients should be informed of the X.

(3) X: At the time of X. A X is not recommended if there is X. X of a X. There should be an X. This recommendation only applies to the X.
(4) X are X. This X on an X. X should be X
Therefore, the following criteria should be considered:
(i) X should require documentation that X.
(ii) X is better X.

(iii) Based on X.
(5) No more than X.
(6) Best evidence does not support X. No more than X.
(7) It is currently not recommended to X or unnecessary treatment.
(8) X should not be X.
(9) X is not generally recommended. When required for X.
(10) X is not a stand-alone procedure. There should be evidence of X.

Per evidence-based guidelines, and the records submitted, this request is non-certified. ODG recommend X and X. The guidelines specify that X. There also needs to be evidence that the X. Letter of appeal dated X noted that the patient X. The patient reported that X pain would X. The X noted X. However, as previously noted, X. Clarification is needed regarding what X. Additionally, there was a X. Therefore, the request for X is not medically necessary 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**

☒ **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)**