MedHealth **R**eview, **I**nc.
422 Panther Peak Drive
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

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

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a X. Injury occurred while X was X. X experienced a X.

A review of records indicated the X. The patient presented for X. X was doing X own X. X continued X. X had included X.

The X impression documented X. There was X. There was X. There was X. There was X. There X. Findings documented a X.

The X report cited a X. Pain could X. X would X. X was X. X documented X. X was documented as X. The X was documented as above. X-rays of the X. The diagnosis was documented as X. The patient had X. At this point with this X would be in the patient's best interest. The X with X.

The X review determination denied the request for X as not medically necessary. The rationale stated that that there was a X to support the medical necessity for X. The requests for X. As the X was not supported, the X was not medically necessary.

The X review determination denied the X as not medically necessary. The rationale stated that guideline criteria had not been met. The patient X. There was X. The available records did X as recommended by current evidence based medical guidelines.

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

The Official Disability Guidelines recommend X.

The Official Disability Guidelines recommend X when the following criteria have been met: History of X.

The Official Disability Guidelines recommend X. X and X.

This patient presents with X. X has pain X. Clinical exam findings include X. There is imaging evidence of X. Under consideration is a request for X. Guideline criteria have not been met as outlined above to support the medical necessity of the X. There is no X of a X. There is no documentation of X. Detailed evidence of a recent, X has not been submitted.

There is no clear evidence of X. There is no X noted to support the medical necessity of this request as an exception to guidelines. Therefore, the request for X is not medically necessary. As the associated X is not medically necessary, the request for X is also not 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 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)**