AccuReview

An Independent Review Organization
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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:

This provider is board certified in 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]:

X MRI of the X by X, MD. Impression: X. 2. X of the X. 3. X is X. X associated X.

X: Follow Up Medical History Form dictated by X, MD.
Claimant returns after X. X reviewed: stated X. Assessment and Plan: X. Has X. Recommend X. If the X.

X: Follow Up Medical History Form dictated by X, MD. follow up X. Claimant presented with clinical exam findings of X. Continued X. X has been X. X and X. Reported X. Assessment and Plan: Claimant with now X. X has X. Re-submit for X.

X Follow Up Medical History Form dictated by X, MD. Claimant now X and X. X reported X. Pain X. Was X. Reported X. X: can X. Reported X. Assessment and Plan: Claimant with X. This is X. Plan to repeat MRI to re-evaluate X. May need to X. Discussed options that is there is still X. Start with MRI. Can continue X.

X performed by X, MD. Reason for denial: The claimant has continued symptoms. Per ODG and would probably X. After the peer discussion with Dr. X and X DR. X agrees the MRI will just show X. Therefore, the request for the repeat MRI of the X is not medically necessary and is non-certified.

X: Letter for Reconsideration dictated by X. The injury has been over on a X. The MRI is needed to determine why X. Please reconsider your decision for this X.

X Post-Operative Note dictated by X, MD. Claimant reported X. X: History of X. Doing X.

X UR performed by X, MD. Reason for denial: The claimant is X. The claimant has X. No medical records are attached to justify X. There is X. No X. As per guideline, X. Given the available information, X.

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

The previous adverse determinations are upheld and agreed upon. The request for X is denied. This claimant X. In X. A X was recommended. There are X. X would be X. Based on the records reviewed, the request for X is not medically necessary. Therefore, after reviewing the medical records and documentation provided, the request for X is not medically necessary and furthermore denied.

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)