AccuReview
An Independent Review Organization
P. O. Box 21
West, TX 76691
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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: Daily Note/Billing Sheet dictated by X. CC: X. Assessment: X. Claimant is X.

X: Daily Note/Billing Sheet dictated by X. CC: X. Claimant has X. Reported X. X reported a X. Stated X. Assessment/Diagnosis: claimant is X. X treatment X.

X: Daily Note/Billing Sheet dictated by X, MS. CC: X. X with X. Assessment/Diagnosis: claimant was X. Claimant was X.

X: MRI X, MD. Impression: 1. X. Would clinically X. 5.

X, MD. Claimant presented X. X reported X. Current medications: X. Assessment: X. Plan: X. Claimant is X with X. X is X. Best option for pain X.

X: Operative Report dictated by X, MD. Preoperative Diagnosis: X. Postoperative Diagnosis: X.

X: Post-Operative Note dictated by X, MD. CC: X. Assessment and Plan: X. Doing X.

X dictated by X. CC: X. Assessment: claimant presented to X. Recommend X. Plan: X.

X: Post-Operative Note dictated by X, MD. CC: claimant reported X. Assessment/Plan: X.

X: Daily Note/Billing Sheet dictated by X MS. CC: X. Assessment: claimant X. Claimant was X. It is deemed medically necessary that claimant X.

X: Daily Note/Billing Sheet dictated by X, PTA. CC: X. Assessment: claimant is X. Claimant X.

X dictated by X. CC: X. PE: X. Assessment: Claimant is X. Claimant X. Plan: X.

X: Post-Operative Note dictated by X, MD. HPI: claimant reported X. PE: X. Assessment: X. Plan: X.

X: Pre-Auth Request dictated by X. Requested X.

X: UR performed by X, MD. Reason for denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The current request in X recommendation and that X were not identified to support ongoing supervised X.

X: UR performed by X, MD. Reason for denial: Based on the clinical information

submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, X is recommended to X. In the case, a request was made for X. However, the current request exceeds the guidelines recommendation in addition to the X. Furthermore, there were X presented on the X. Lastly, X were not identified to support ongoing 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. The claimant underwent a X. X was X. X has been X. In X the claimant was noted to have X. X was recommended. The Official Disability Guidelines (ODG) X. The recent request for X exceeds the ODG recommendations. There are no X in this case to support X. This patient can X. Therefore, after reviewing the medical records and documentation that was submitted, the 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)