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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: X

REVIEW OUTCOME:

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

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was X, while X. X reported X was at X. X had X. X was X with X. X was seen by X, MD on X for a X. X noted X and X. X described this X. X continued to X. It seemed to X. X continued with X. On examination, the X. The X was X. X was noted X. X the X. There was X. The X. X was X. X dated X were reviewed and noted to X. An X was done X and X. The X. X of the X and of the X. X was X were X. Treatment to date X. Per a Utilization Review Adverse Determination Letter dated X, the request for X, was denied by X, MD. X: "Per evidence-based guidelines, X is not recommended for X. In this case, the patient was X. X noted X and X. X this X. On exam, X was X. There was X. The X and there was X. They planned for X was made. However, there X from this non recommended request. Moreover, the X. In addition, the X. Clarification is also needed on how the request would X recommendations and X. The X request for X was not certified, thereby X the medical necessity of the X requests. 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 a Reconsideration Review Adverse Determination Letter dated X, the appeal request for X, was denied by X, MD. X: "An Appeal request for X and X; however, there were X the previous reasons for denial. There were X. Furthermore, the X showed X. There were X. With this, the previous denial is upheld. The request is not medically substantiated. As the X is not deemed medically necessary at this time, the X request for X are thereby not supported. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There were X the previous reasons for denial. There were X and X the requested X. Furthermore, the X. There were X. With this, the previous denial is upheld. The request is X. As the X is not deemed medically necessary at this time, the X request for X are thereby not supported."

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

The ODG supports X. The ODG does not have a specific recommendation regarding X. A review of current medical literature, including the below article in X. The X and X. The documentation provided indicates that the X. There have been X. Treatment has included X. An examination documented X. X noted X. The treating provider has recommended X. Given the X and X and X, the requested X would be considered medically necessary. A X possible X would be supported given the X. Given the X would be X as this can X.

As such, the requested X is supported as medically necessary, in my medical opinion.

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

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL