CASEREVIEW
8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a X who sustained an injury on X. Per an X Evaluation by X dated X, the patient had X noted at X. X noted was at X. X noted was at X. X discrimination in X. The patient was diagnosed with X.

On X, X, MD performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines reference above, this request is non-certified. Per evidence-based guidelines, X are recommended for X. In this case, the patient's current set do not meet X needs X. The provider recommended the need for X. However, a clarification is needed given the chronicity of the injury dated X. Guidelines support replacement X. Telephone contact was established with a provider designee for the office of Dr. X. It is stated the patient had a recent X purchased in X with in the last X months. X is not satisfied with the X. Medical necessity is not established. The current X works as expected and guidelines do not support replacement in less than X year intervals.

On X, X, MD performed a UR. Rationale 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. During peer discussion the provider indicates that the patient noticed the X were not X but during the X day guarantee, did not return the X. Additionally, there were no warranty claims made in the X. The provider notes that the X are now just over the X -year warranty and the patient is requesting an X. There were no X to warrant a change in X at this early juncture. The request is recommended for noncertification.

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

Determination: Denial of X is UPHELD/AGREED UPON since there is record of a X provided a little over X year ago, and there is no documentation of significant clinical changes to require a X prior to ODG recommended frequency of every X years. 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 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)