Medical Assessments, Inc.
4833 Thistledown Dr.
Fort Worth, TX 76137
P: 817-751-0545
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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:
The Reviewer 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]:
The claimant is a X whose date of injury is X.

X of the X and X with contrast by X, MD. Report revealed X. No X.

X report by X, MD. The claimant underwent X.

X: Progress notes by X, MD. The claimant referred for X pain consult. X stated pain began X. The X report was not submitted for review. The pain was described as X. X felt X could X due to X. X and X. X stated X had so much pain X could X. X was currently X. The X and X were not documented. X endorsed only a X and X. X present for follow up and stated X was X. The pain was rated as X.

X: Letter of medical necessity by X, MD. The claimant suffered from X. In the past month, X reported an average pain level of X with X. The claimant had X with X treatment including X, but X and X.

X: UR performed by X, DO. Rationale for denial: Based on the clinical information submitted for this review and using the evidence-based guidelines, this request is non-certified. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

X: UR performed by X, MD. Based on the clinical information submitted for this review and using the evidence-based guidelines, this request is non-certified. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. Exceptional factors are not identified to warrant recommendation versus non recommendation by the guidelines.

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

Based on the clinical information submitted for this review and using the evidence-based guidelines, this request is non-certified. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. Exceptional factors are not identified to warrant recommendation versus non recommendation by the guidelines.

Therefore, the request for X is found to be non-certified.

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)