



MedHealth Review, Inc.
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DATE NOTICE SENT TO ALL PARTIES: X

IRO CASE #: X

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 a X who is board certified in X. The reviewer has been practicing for greater than X years.

REVIEW OUTCOME

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

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a X with a history of an occupational claim from X. The mechanism of injury is detailed as the patient went X. Prior treatment included X. Pertinent medical history includes X. The current diagnosis is documented as a X. An MRI of the X on X revealed there was X.

The pain evaluation on X documented the patient had X. The patient had X. The patient reported X. On X examination, the patient had a X. The patient had X. The treatment plan included a X.

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

Per evidence-based guidelines, and the records submitted, this request is non-certified. Per ODG, an X is recommended on a case-by-case basis as a short-term treatment for X. There should be evidence of X. X is not recommended with an X. In this case, the patient had X. The patient reported a X. On X examination, the patient had a X. A recommendation was made for an X beginning at the X. While there is evidence of X on examination and imaging in the X guidelines do not support X. Additionally, per ODG, X. Therefore, this request is not medically necessary.

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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY 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)**