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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

PATIENT CLINICAL HISTORY [SUMMARY]:
X who sustained an X. X was X. The diagnosis was X. A X note dated X was documented by X. X had X. X reported X. X was X. X have the X. X was status X, with X. X was X. X had an X. X had X and X. X stated X was X. X did X. X had to X. X reported X. If not, X to X. X got X and the X. The X. X was X, and X. It was X. X was with X and X. X had X. X continued to X. There was X. X also continued to X. The X. X continued to X. X was X. It was noted X was a X. X was recommended X. X was medically necessary because the X. On X, MD evaluated X in follow-up. X was status X. X was X, and X had continued to X. There was X or X. X noted some X. X or X. X had been X. There were X. X needed X; had not X. X and X. X of X, and X. X showed X. On X requested that X. Pain control was X, and X had X. X noted some X. Examination was X. Dr. X assessed X was X. X was X. X must X, and X. Dr. X recommended an X, as X was X. X was to X. Treatment to date included X. An MRI of the X, revealed X. An MRA of the X, identified X. Per a utilization review adverse determination letter and a peer review by X, MD, dated X the request for X was not medically certified. Rationale: “ODG does recommend X. The patient has X. Furthermore, ODG does not recommend X. At this stage, the X. The

documents provided X. For these reasons, the requested X is not medically necessary and is non-certified." Per a letter of medical X, Dr. X and provided X. X documented that X was diagnosed with X and X. Due to X. X was X. For treatment, X was referred to X. This would be incredibly necessary, considering X had X. X had been X, and it did X. X was an X. X was an ideal candidate for X. In Dr. X experience, patients with X. Dr. X initially evaluated the patient on X. X had responded X. In X professional medical opinion, X would X. X continued X. X was X because of X. Per a reconsideration review adverse determination letter dated X and a peer review by X, MD dated X, the appeal request for X was denied. Rationale: "In this case, the claimant presented with X. The X revealed X. The claimant is noted to have had X per guideline recommendations. As such, an X would exceed guideline recommendations and the claimant should be X. Thus, medical necessity has X. Therefore, Appeal X is not medically necessary."

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

The ODG recommends up to X. The ODG does not recommend X. The provided documentation indicates the X. Per the X note from X have been X. There is X. There are no documented X outside of the guideline recommendation. Based on the ODG recommendations and available information, X are 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 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