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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 a X when X was X. The diagnosis was X. X visited X, MD for X. X were X. X included X. There was X. X did not help. X had been X. X had a X. X noted X. X had X. On X, the X. X had a X. X also had X. Examination of the X and X. X of X and X. MRI showed X. X-rays were re-reviewed and showed X. X was X. An MRI of the X demonstrated X. There was associated X and X was noted X. X was noted, which included X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was noncertified by X, MD. Rationale: "Per evidenced-based guidelines, X is indicated for patients with X. In this case, the patient presented with X. Examination of the X. MRI of the X revealed a X. A request was made for X, however, X findings were insufficient to X the request. There was no evidence of X. Moreover, significant X. Also, there was X noted. Furthermore, X were not established before X. There was no documentation of the patient having X. In addition, it was noted that the patient was a current X. X of X and X were not identified. Based on the clinical information

submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. X and X before considering X. There was no documentation of the patient X." Per a reconsideration review adverse determination letter dated X, MD denied the appeal request for X. Rationale: "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 evidence-based guidelines, X is recommended for patients with X, In this case, the patient X. The pain was X. The patient also reported X. X was X and was a X. Per the exam, the patient had X was noted. The treatment plan noted X was necessary as the X. A request for X was made. However, a significant X was X. X are criteria prior to considering a X. Moreover, the medicals failed to mention that the patient had X. X spoke with Dr. X who X plan; therefore X withdrew this request."

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

The ODG supports X for the treatment of X. The documentation provided indicates that the injured worker reports X. Treatment has included X. An recent X. The injured worker reported frequent X. An MRI documented a X. The treating provider has X. Based upon the documentation provided, while there has not been a documented X. When noting X would be supported. It is unlikely that additional X would result in X. As such, the requested X would be considered 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