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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 was injured on X. The mechanism of injury was X. The X. An X. There was X. X are also a X. X and X. X and X. On X was X, MD for a follow-up of X. It was noted that X. X was X. X showed X. Dr. X and X. The plan was to X and X. Treatment to date consisted of X. Per a X and X was non-certified. Rationale: "The ODG recommends a X. The ODG supports X. The ODG does X. Based on the clinical documentation provided, the X. X has X. There were X. Additionally, the submitted documentation indicates that the X is being requested. Based on the ODG recommendations and available information, the X is not medically necessary. X the request is non-certified." In an undated letter, Dr. X requested a X. X stated it was a X. In accordance with X, and continued X. Continued use of the X and medically necessary at the X. Per X dated X, the appeal request for X was non-certified. Rationale: "Regarding the request for X. X is recommended as a X. The guidelines do not recommend X. The records indicated the patient was X. The patient was advised to X. However, as noted previously, there were X requested

outside guideline recommendation. There was no new documentation received to overturn the prior determination. Additionally, there X. In agreement with the prior determination the request for X is non-certified."

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

Based on the clinical information provided, the request for X is not recommended as medically necessary. There is X to support a change in determination, and the previous non-certifications are upheld. ODG X that X is recommended X. For other X providers available for referral. The Official Disability Guidelines note that X is not recommended X. The Official Disability Guidelines support X. The submitted clinical X. When X should be noted. There are X documented. There are X.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

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