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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 when X was X. X began X and X. X and X. The diagnosis was X other X. On X, MD evaluated X following X. X apparently was X. Dr. X reviewed the X and X. X had a X. X had X. This was the X. Dr. X that X. X an X by X. X reported X. X were as follows: X and X. X was X and X. X included X. X Patient Inquiry X. X showed X. X on the X. X showed X and X. X was X. X and X. An MRI of the X and X. There X. X of the X were noted. Of note, there was X. This X. A X but X. There was X noted. Of note, there was X only, but there was X. If there was X. Treatment to date included X. Per a utilization review X as not medically necessary. Rationale: X. X examination from the X. X were X. X were X. Reflexes X. X and X. There were some X. X on the X. At this time, based on X. Since the request cannot be modified without a peer to peer, the request is non-certified." Per a reconsideration review adverse determination letter dated X MD, recommended that the X request for X be noncertified. Rationale: "The claimant's issues with X. ODG's X Guidelines is therefore applicable. The request in question, however, represents a request for X in ODG's X. It was X. ODG X. Here, X made by

the X. Therefore, the request for X is not medically necessary."

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, and the previous denials are upheld. Per a utilization review adverse determination letter dated X, MD recommended that the X be noncertified as not medically necessary. Rationale: X. X examination from the X. X were X. X were X. X were X. X and X. There were X. X on the X. At this time, based on X. Since the request cannot be modified without a peer to peer, the request is non-certified." Per a X, MD, recommended that the prospective request for X be noncertified. Rationale: "The claimant's issues with X. ODG's X Guidelines is therefore applicable. The request in question, however, represents a request for X. It was unclear why the X. ODG further X. Here, commentary made by the treating provider to the X. Therefore, the request for X is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no specific information provided X. The request for X. It is unclear what significant benefit is expected for this patient who was injured X.

Given the X. Therefore, the request is upheld and 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