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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 injury on X. X and X. The diagnoses included X. X was seen by X MD on X. X returned for follow-up after X were performed. The X and reports were reviewed as read by Dr. X and there was some X. The X along the X. There was X or X. There was X noted in a X. X continued to have X. X with a X. X was X. X had X. X and the X. Treatment to date included X. Per a utilization review adverse determination letter dated X, DO, the request for X was non-certified. Rationale: "The claimant has a history of X and had X, however, the requested procedure is still considered investigational and not recommended per the ODG guidelines. In the case of X have been requested primarily to X and these are not recommended due to X. As such the request is not considered medically necessary." Per a reconsideration review adverse determination letter by X, MD on X, the request

for X was non-certified. Rationale: “ODG does not support X. Within the medical information available for review, there is documentation of a request for X. However, there is no rationale supporting the request (where ODG states that X are not recommended and that such X have been requested primarily to X. As such, the currently requested 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 requests are non-certified. Per a utilization review adverse determination letter dated X, DO, the request for X was non-certified. Rationale: “The claimant has a X, however, the requested X is still considered X and not recommended per the ODG guidelines. In the case of X have been requested X and these are not recommended due to lack of sufficient evidence. As such the request is not considered medically necessary.” Per a reconsideration review adverse determination letter by X, the request for X was non-certified. Rationale: “ODG does not support X. Within the medical information available for review, there is documentation of a request for X. However, there is X the request (where ODG states that X. As such, the currently requested X is not medically necessary.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that X are recommended only for X, but not for X. When treatment is outside the guidelines, X should be noted. There are no X of delayed recovery documented. There is no current, detailed X submitted for review. Additionally, there is no X of X.

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

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