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Description of the service or services in dispute:
x

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified x

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:
x

☑ ***Patient Clinical History (Summary)***

X is a X who sustained an injury on X. The mechanics of the injury was not available in the medical records. The diagnoses included X.

X was seen by X, MD and X, MD on X. X returned to the clinic for evaluation of X. X continued to have X. It was X. X had failed to improve despite physical therapy and X in the past. X pain X. X had X into X. X was X. X pain was X. X had X. X was X. X had X. The pain was X and X. X had continued X. The X. X showed X. X of X. X was X and the X. X was X. There was X. On X visited Dr. X. X continued to have X. X was X. The X was X. X felt like X. X stated that X. X rated the pain X. X had X. X pain had X. X had X and X. X had a history of a X. The request for X was denied by Workers' Compensation. X showed X. X showed X on X. X was X. X was X. There was X. Dr. X that based on X.

A X showed X. X to X. There were X. No X was noted. An MRI of the X demonstrated, X. There was X. An X of the X was noted. X of the X. There was a X of the X. There was X. X was X.

Treatment to date included X.

Per a utilization review by X, MD on X, the request for X was non-certified. 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. The presented findings were X. There was X. Also, X. There were X in the X. Detailed objective evidence of a recent, reasonable, and / or comprehensive non-operative treatment trial and failure should be considered prior to considering procedural levels of care. Pending this, the request may not be considered at this time.”

Per a utilization review by X, the request for X was non-certified. 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. There was X. Moreover, X could X. Clarification is needed if the X. There were X noted.”

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG supports X. A X is supported when there is X. A X is when there is a history, X. A X is supported for X. The documentation provided indicates that the X. A X documented X. A repeat X. The provider has requested a X. Given the X and X. The X has X. Given the X. As such, the requested X is recommended for certification. Given the documentation available, the requested service(s) is considered medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐
- ☐ DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Medical Literature (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)