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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 X. X was X, which X. The diagnoses were X. On X underwent X. X had X. X was evaluated on X for a X. X reported X. Medications include X. The X were X. The plan was to X for X. A X report dated X. Treatment to date included X. A peer review dated X was X, MD. He opined: X has been requested. As noted above, the patient X. It is appreciated that the patient reported X. However, the medical records do not establish X and X including X, as required by the guidelines. X, the patient does not meet guideline criteria for that requested X. Therefore, my recommendation is to NON-CERTIFY the request for X. In a letter dated X, Dr. X stated: X and X. Prior to the X. The patient had X. X pain levels X. X also stated that X and X. X and X was X. Since the X has been X. In summary, my patient's clinical records document that X. I feel the X. I would appreciate a prompt review of this request. Should you have any questions, I would be pleased to discuss this case with you or a review panel. I ask that you provide a favorable

written authorization for the procedure." Per a peer review dated X by X, MD the denial for permanent X was upheld. Rationale: "Within the medical information available for review, there is documentation of a request for X. Additionally, there is a previous adverse determination X. Also, X has X. The X. However, there is X of X. Also, it was noted X did X were not documented. As such, the current request is not medically necessary and is given an adverse determination. The original denial is upheld."

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. A peer review dated X was completed by X, MD. X: has been requested. As noted above, the patient X. It is appreciated that the patient reported X. However, the medical records do not establish X, as required by the guidelines. Absent the above, the patient does not meet guideline criteria for that requested X. Therefore, my recommendation is to NON-CERTIFY the request for X. Per a peer review dated X by X, MD the denial for X was upheld. Rationale: "Within the medical information available for review, there is documentation of a request for X. Additionally, there is a previous adverse determination rendered due to lack of documentation of reduction in specific medication use and functional benefits including specific activities performed. Also, the X. The X. However, there is no documented evidence of X. Also, it was noted X use were not documented. As such, the current request is not medically necessary and is given an adverse determination. The original denial is upheld." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. Current evidence-based guidelines note that following a X. Documentation should also include whether any X. Although the patient subjectively reports X. The patient's medication X.

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