



MedHealth Review, Inc.
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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

The reviewer is a Medical Doctor who is board certified in X

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a X

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was diagnosed with X. Was at X. Current X include X. Previous X. MRI of the X. An MRI referenced in the X note states X. Prior treatments include X.

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

Per evidence-based guidelines, and the records submitted, this request is non-certified. Per ODG, X are recommended for X. X are recommended for X. The available medical records indicate that the patient has X. There are X. Additionally, the X note requests X as a treatment for the patient's X. X were recommended at that time for X. The X of the requested X is X. Compliance with the X guidelines and medical necessity are not established by the information provided. Therefore, this request is 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**