AccuReview
An Independent Review Organization
P. O. Box 21
West, TX 76691
Phone (254) 640-1738
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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:

This provider is board certified in X

REVIEW OUTCOME:

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

Provide a description of the review outcome that clearly states whether **medical necessity exists** for **each** of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
X MR X dictated by X MD. Impression: 1. X with X. 2. X and X. 3. X 4. X.

X: UR performed by X, MD. Reason for denial: This request is not supported. Although this claimant has X and there are X. The progress note dated X stated that there was X. X other X. Considering the X of these X there is X. As such, this request is not medically necessary.

X: Progress Note dictated by X MD. CC: X since a X. At the X, the claimant, and a X.

When X and X and X. X was X. X had X. Subsequently, the claimant was X. Later X was sent X under the care of Dr. X who performed an X. Claimant presented with a X. The X from X with X include X. X was X with X. X reported X. The X and X. Claimant was X. X reported that the X. X had and X. X returned to X and had X. Since X after an X. X was X. Medications: X. There is X and X. Plan: X the need for X including X. Apply X and X. At this point will submit for IRO reconsideration of denial, should X. Claimant will continue X and X.

X: UR performed by X, MD. Reason for denial: The claimant has X. However, previous treatment for this claimant has included an X. This X. There is X. Furthermore, this X and X. There are X to continue any X. Accordingly, considering this history, this request is not medically necessary.

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

Previous adverse determinations are upheld and agreed upon based on the records submitted and peer-reviewed guidelines. The claimant has complaints of X. However, previous treatment for this claimant has included an X. This X only provided X. There is X to be any X or X. Furthermore, this X is not indicated to be a X and should be X. There are X to continue any X. Accordingly, considering this history, this request is not medically necessary. Therefore, after reviewing the medical records and documentation provided, the request for X, as an outpatient is denied.

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

- [x] MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

- [ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

- [ ] MILLIMAN CARE GUIDELINES

- [x] ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

- [ ] PRESLEY 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)