CASEREVIEW

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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 physician is a Board-Certified 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]:
The claimant is a X. X was a X. Per X dated X, the X is X. X-ray X. A X. Per the medical report dated X, the X was X. The X was X. Per the medical report dated X, the patient was X. On exam, X. X on the X. The patient was X. X reported X. According to the office visit notes X had X. X was on X and X. The X level was X. On exam of the X noted X. Treatment plan included X.

On X, MD performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based peer-reviewed guidelines referenced below, this request is non-certified. The findings presented in the medical reports were still limited to establish the X the need for the request. Also,

the medicals submitted X. Furthermore, the guideline indicated that although X. Clarification is needed regarding the request and how it would affect the patient's clinical outcomes.

On X, MD performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based peer-reviewed guidelines referenced below, this request is non-certified. The objective findings in the most recent medical were X the request. There was limited evidence that there was a X the need for the request. Also, the medicals submitted cannot establish X. In addition, a clarification is need about the request since it was certified on X confirmed the X. Pending clarification of the request, this is not supported at this time.

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

The request for X is not medically necessary at this time, X.
This patient X. X was X. X continues to have X. X was recommended. The Official Disability Guidelines (ODG) supports X. The X. It is not X. In this case, the imaging studies have confirmed that this patient does not have a X. X is not medically necessary for this patient, as further testing must be done.

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

☐ 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)