Health Decisions, 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:

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 X. X reports the pain has X. X reports pain when X.

X: Encounter with X. The patient reports that the X. X says it X. It just gets X. X says that the X. Pain Scale X.

X: Encounter with X MD. The X is X. Exam: There is X. Assessment: X. Pan: Perform Pain X.

X: Recheck Report by X, MD. X has got X. X has got X. We gave X a X. X is X. X is X. Exam: X. Plan: I recommend referral to a possible X.

X: UR performed by X, MD. Rationale for Denial: Per the Official Disability Guideline, X is recommended as an option for X. X is recommended as an option for X. In this case this claimant has continued X. X has X. However, there is limited documentation of clinical findings of X. Therefore, the X is not medically necessary.

X: UR performed by X MD. On X the claimant presented to Dr. X with X. Exam of the X. However, after reviewing the documentation provided, there are X. As such, the X is not appropriate and medically necessary for this diagnosis and clinical findings.

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

Based on the records submitted and peer-reviewed guidelines, X is recommended as an option for X. X is recommended as an option for X for patients who have X. In this case this claimant has continued X. X has tried X. However, there is limited documentation of clinical findings of X. Therefore, the proposed treatment consisting of X is not medically necessary. Therefore, this request is non-certified.

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)