



MedHealth Review, Inc.
422 Panther Peak Drive
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

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

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

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a X who sustained an X. Injury occurred when X and X. X was X. X was X.

A review of records indicated that the injured worker was X. X included X.

The X MRI impression documented X. There was X.

The X MRI impression documented X. There was X. There was X. There were X. X documented there was X. There was X.

The X and X. X had tried X and X with little relief. X reported X. X documented X. X documented X. X x-rays were obtained and showed an X. MRI finding were documented as above. The diagnosis included X. It was noted that the patient reported X. A X was performed to the X.

The X progress report indicated that the patient was seen in X. X reported that the X. X documented X. The diagnosis included X. The treatment plan recommended X.

The X utilization review non-certified the request for X. The rationale stated that the submitted X did not reflect the X. It was noted that X was supported but the provider was not reached to obtain agreement for this modification. The X.

The X utilization review non-certified the request for X. The rationale stated that the X. The provider reported that the patient X. There was a X. The request was not medically necessary at this time pending a second opinion concerning the patient's X.

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

The Official Disability Guidelines recommend X. Criteria include X. Guidelines state that X.

This patient presents with X. X with X. Clinical exam findings are X. X has X. X had a X. Under consideration is a request for X. Guideline criteria have not X to support the X. The

symptoms are reported to be X. There is imaging evidence of X. There are X. Therefore, this request for X 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)**