IMED, INC.

PO Box 558 Melissa, TX 75454

Office: 214-223-6105 * Fax: 469-283-2928 * email: @msn.com

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:

MD, 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

The X who sustained an X and X. The claimant had been X. The X did X. As of the X, the claimant had been X. The claimant had been X. This evaluation was a telemedicine evaluation due to COVID. X were included. The X was X. The claimant was X. The X was denied by utilization review due to the X. There was also X.

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

Regarding the use of X. The current evidence based guidelines do not recommend X. the X with X. The X the X. There was also X as recommended by current evidence based guidelines. Given these issues which do not meet

guideline recommendations, this request is not considered medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES