



MedHealth Review, Inc.  
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## Notice of Independent Review Decision

### **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**

The reviewer is a Medical Doctor who is board certified in X.

### **REVIEW OUTCOME**

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

X

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

X

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This X sustained an injury on X when X was X and X. MRI of the X has X and X.

Progress note dated X notes the X has been X. X does have pain if X and X. The pain is X. There is pain at X. X has

noted some X. X has attempted X and X. MRI is noted to show evidence of X; and X. Exam notes X, X, and X. Exam of the X reveals X. X on was noted. No significant X was noted. X were X. The X was noted along the X. X was X for X. This was X and caused the X. X and X were noted with X. X were noted to not reveal any evidence of X. Recommendation is made for X.

Progress note dated X notes continued X. X has pain if X, which is consistent with an X. Again, this X. X also on X during X last visit had a X. Exam of the X reveals X. X noted. X was noted along the X. X was X. This was X. X were noted with X. This X. Discussion was had regarding the denial of the X. This provider notes that the requested X was denied as the reviewer noted there were no documented X. The provider notes that X was documented in the previous exam X. X will again be requested.

Progress note dated X states that the previous review deemed the X intervention medically necessary under ODG guidelines, but the X request was attached to the X request, and the whole request was denied. X continues to have X. X has pain if X, which is consistent with an X. X continues to have X with X. Exam of the X on X. There was X noted. X was noted along the X. X was X. This was X and caused the X. X and X were noted with X and X. Request is again for X.

A X denial dated X revealed that despite the X being reasonable and medically necessary at the time it could not be supported as the X was not able to be supported without a peer to peer discussion and approval.

A X denial dated X indicated that there had been no X. X dated denial from X as above.

Additional records reviewed (and duplicative) were from X and X from a X. Clinical findings as documented are compatible especially with a X, including X. The X and X dated X were also reviewed. The X was noted.

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

As per ODG, “Recommended as indicated below for X. Not recommended for X in the X.

This X sustained an injury on X and is undergoing treatment for a X. Progress notes have the injured worker noting X, which is consistent with an X. X continues to have X. Exam of the X. There was X noted. X was noted along the X. X was X. This was X and caused the X. X and X were noted with X. X the X. Provided documentation demonstrates X that are corroborated by imaging studies. Therefore, the requested X and necessary.

Regarding the X, the ODG indicates, “Recommended as an option following X, but not for X. X use may be approved up to X. X is not supported by X, which are recommended for most X. However, there is limited documentation of reasons why X. Therefore, the requested X is not medically reasonable or 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)**