MedHealth **R**eview, **I**nc.
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Notice of Independent Review Decision

Amended report

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 agrees with the previous adverse determination regarding the prospective medical necessity of a X.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a X who complains of X. As of X, the pain is in the X and is X and X. The pain scale is X. X history is X and X. Medications include X and X is X. X is X in X, X, X and X. X are X with X which is a X and X is X in X. X is X on the X. The X from X reveals an X, X with X, and X. The X indicates a X is necessary. The follow up note on X indicates

a X with X of X and X of X. X results have not changed. The X is still assessed with X. X MD report of X indicates the X is not causally related to the date of injury. Dr X opined that the service is not medically necessary because it does not follow the ODG guidelines. Dr. X opined that the X is not necessarily as it is X and the X has been established.

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

Official Disability Guidelines- Chapter X
Per evidence-based guidelines, and the records submitted, this request is non-certified. Per ODG, "X are recommended for diagnostic purposes to evaluation X in patients status X. X are recommended for X." The available medical records indicate that the patient has X with X. There are X in the recent X but the X of the requested X is not apparent. Compliance with the X guidelines and medical necessity are not established by the information provided. Therefore, this request 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)**