MedHealth Review, 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
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 massage X.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a X claimant with a history of an X claim from X. The mechanism of injury was detailed as a X. The request is for massage X. The current diagnoses were listed as X, X, X of the X, and X. X were undisclosed. Prior treatment had included X, X, X, X, X, and a X program. A progress note dated X reported X but X progress. Pain is

rated X, with X restricted. There is X and X. Exam X, X. There is a plan for X.

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

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition Chapter: X

Regarding the request for X, ODG indicated Massage for X is recommended as an option in X. X administered by professional providers has shown some proven efficacy in the treatment of X, based on quality studies. X devices are not recommended. Based upon the medical documentation presently available for review, the above-noted reference does not support a medical necessity for this specific request. X is recommended as an option in X. There is no documentation that X is in X.

Recommended as an option in conjunction with recommended X. X administered by professional providers has shown some proven efficacy in the treatment of X, based on quality studies. X devices are not recommended.

Regarding the request for X, the claimant presented with X and X. The provider plans for X. There is no indication if the X has been approved. In addition, the X is not specified in the request. Additionally, there is no documentation that the X is in 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
- [x] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- [ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- [ ] MILLIMAN CARE GUIDELINES
- [x] 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)