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

Amended Report X
Notice of Independent Review Decision

SENT TO:

DATE NOTICE SENT TO ALL PARTIES: X

IRO CASE #: X

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:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

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]:
The date of injury is X. X has a diagnosis of X. X was evaluated by the nurse practitioner on X for X back. X was using a X. X still had persistent pain that was constant. X has diagnostic X. X was taking several medications. Physical examination did not include the cervical X, but the X back was evaluated. On X, X saw the nurse practitioner again for his lumbar X and had X. The cervical X

was not examined. On X, X reported radiating pain from X. Cervical X examination revealed X. X had X of the X extremities and X. X had X and other X. X had X. X was diagnosed with X. On X, X stated X. Cervical X evaluation was the same. X were recommended. X had an X on X that revealed X.

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

Per ODG, the requested treatment is recommended as a short-term treatment for X. This treatment should be administered X. Not recommended for treatment of X. X are not recommended as a treatment for X X back pain or for non-specific X back. X at post-surgical fused levels are not recommended. See specific criteria for use below.

X.

Per evidence-based guidelines, and the records submitted, this request is not justified at this time. There is no data submitted for appeal that would change this justification . The X remains ambiguous. Also, there is 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)**