



MedHealth Review, Inc.
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Notice of Independent Review Decision

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a X with a history of an occupational claim from X. The mechanism of injury is not identified. The current diagnosis is post-laminectomy syndrome, lumbar region. The comorbidities include X. On X, the claimant reports neck pain, lower back pain and lower extremity pain. The claimant is currently taking X. The claimant continues to have pain over the pump site. The claimant has X. On exam the claimant uses a X. Gate is X. Left upper buttocks at previous battery site is hardened.

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

X.

The proposed treatment X. ODG guidelines state that X is recommended only as a treatment alternative for selected patients for specific conditions after failure of at least X. In this case, the claimant reports neck pain, lower back pain and lower extremity pain. The claimant is currently taking X. Claimant continues to have pain over the pump site. The claimant has X. There is no documentation that the claimant has had at X. There is no documentation that psychological evaluation has been obtained. There are no significant objective findings in the physical examination to support the request.

In addition, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. There is no documentation that the claimant has had at least X. There is no documentation that psychological evaluation has been obtained. There are no significant objective findings in the physical

examination to support the request. As such the 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)**