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PATIENT CLINICAL HISTORY [SUMMARY]:
Claimant is a X who sustained a work injury on X. The mechanism of injury occurred when X. X diagnoses included X. X MRI dated X showed X. On X, a X was certified. On X, a X was certified, with this review noting that the previously certified X were never performed. Prior treatments include; X. The procedure follow-up notes from X stated X was X. X from the procedure. Pain was rated X. X was taking X. A question regarding whether X had an increased level of function was answered "X". The visit note dated X by X, MD stated that X complained of X. Pain was rated at X currently and at X, and a X. Pain was X. An X had helped some of the pain. X pain was approximately X. X still had X. Objective findings included X. Additional findings were not documented. A X was planned.

X: UR by Dr X. Rationale- Recommended for X. Repeat treatment is recommended following the same criteria on a case-by-case basis. Available research is X. This procedure, also referred to as X. Criteria for use of X. This procedure is limited only to patients with X. There is documentation of X. While X may be required, they should not be performed at X. Duration of effect after the first procedure should be documented for X. Current literature does not support procedural success without sustained pain relief of at least X months duration; therefore, more than X procedures should never be performed within X months. Approval of X depends on variables such as evidence of adequate X. No more than X are to be performed at one time. If different regions require X. There should be evidence of a X. Regarding diagnostic X, the ODG states, "X should not be given as a "X" during the procedure. The use of X. In this case, X were administered for X during the procedure. Thus, it cannot be determined if the X were valid and performed in a manner

consistent with ODG criteria. As noted in the ODG valid X are a prerequisite for X. This request is not medically necessary.

X: UR by Dr. X. Rationale- Request was denied on X. It was noted that the recent. The records did not state what medication were administered for X during the procedure. Thus, it was concluded that it could not be determined if the X were valid and performed in a manner consistent with the ODG criteria. As noted, X are a prerequisite for X. Dr. X has now appealed this decision, claiming the only X used during the X was X. However, during the phone consultation f/u the day after the procedure, that patient rated X pain X and stated X was taking X. It appears the report represented a pain reduction of X from the X pain level of X that may have been assisted by the pt's use of X within X hours after the procedure, which is not consistent with the guidelines. Given this information, medical necessity cannot be established.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION: The previous adverse decision is Upheld. Based on records submitted and peer reviewed guidelines, this request is not certified. It was noted that the recently completed X. As noted, X. However, the day after the procedure, that patient rated X pain X and stated X was taking X. It appears the report represented a pain reduction of X from the X pain level of X that may have been assisted by the patient's use of X within X hours after the procedure, which is not consistent with the guidelines. Therefore, given this information, medical necessity cannot be established for request for X.

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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESLEY 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)