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PATIENT CLINICAL HISTORY [SUMMARY]:
X: MRI X interpreted by X, MD. **Impression:** 1. X, X. Background moderate X. The X are maintained. 2. Moderate X. 3. X can be seen in the setting of X. No mass is noted within the X. 4. Moderate X with findings suggestive of X. 5. X of the X.

X: Encounter Summary by X, MD. **HPI:** The patient is a X who presents for evaluation of a work-related injury occurred to X on X. At that time X was putting on X. This occurred suddenly. Since that time X has had difficulty with any type of X. Anytime X wants X only is. X is X. **Assessment/Plan:** 1.X. X

X: UR performed by X, MD. **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Given the following circumstances including the lack of conservative treatment of at least a year of X weeks consisting of X. Clarification is needed with respect to the CPT codes requested as there was a discrepancy between issues to be analyzed and the precertification request form, the requested treatment, and how it might affect the patient's clinical outcomes. As the surgical procedure was not deemed medically necessary at this time, associated treatment such as X is not supported. The attestation certifies that the peer reviewer named above has the appropriate scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review and has current, relevant experience and/or knowledge to render a determination for the case under review.

X: Encounter Summary by X, MD. **HPI:** Patient is still having pain and difficulty with any type of X. X was denied on the basis that the patient lacked to conservative treatment of at least X. I would remind the reviewer the patient is X. X has poor function secondary to the X. A X is contraindicated.

X: UR performed by X, MD. **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guideline, X is recommended for patients with significant subjective complaints and objective findings corroborated by imaging reports and after exhaustion of conservative care. In this case, the patient presented with a X. Examination of the X showed X. This caused discomfort. There was a X. Tenderness was noted over the X. X showed X. The provider noted that X was not reasonable in a X that does significant X. The provider also suggests that X with X will not address nor fix X is contraindicated as this will lead to further X. A request was made for X. However, X from X are still not established. Also, the presented clinical findings were insufficient to support the requested X as there was no noted pain with X. There was also no documentation that a X was done revealing X; that the X were not established if it were X. Also, clarification is needed if the patient had visited X preoperatively to make sure X does not have any contraindications to X. As the X request is not established, the X is thereby not supported.

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

The request for X is approved.

This patient injured X at work in X. X has limited X on examination. X MRI demonstrates a X. The treating provider has recommended X.

The Official Disability Guidelines (ODG) supports X in patients with moderate X. Surgical candidates have subjective and objective findings that correlate with imaging studies.

This patient meets criteria for X. X has a significant X. X is a X patient who is involved with X. I do not expect that X will be able to return to this level of work without repair of the X. X is typically performed at the time of X. X will require the X.

The MRI report documents X in the X. X has a positive X test with tenderness over the X. It would be appropriate to perform a X at the time of X repair.

The recommended procedure is medically necessary for this patient.

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)