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PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a X who sustained an industrial injury on X. Injury occurred when X. X felt X. A review of records indicated the patient was under treatment for a diagnosis of X. Conservative treatment had included X. The X MRI impression documented X. The X orthopedic report cited complaints of X. Pain was localized to the X. Pain was aggravated with X. X exam documented X. There was pain and X. The diagnosis included X. The treatment plan recommended an ultrasound guided X to the X, as well as an ultrasound guided X to the X. If X had X or no relief from the X, X might be a candidate for X. The X utilization review determination indicated that the request for X was denied. The rationale stated that the Official Disability Guidelines do not recommend X, and there is insufficient information to support the administration of a X to the X. The X utilization review determination indicated that the request for X was upheld on appeal. The rationale stated that the Official Disability Guidelines do not recommend X, and limit support for X.

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

The Official Disability Guidelines state that X are not recommended in X. Guidelines state that although X have very poor evidence for X with potential for X, higher quality research also results in non-recommendation for most other forms of X. Guidelines recommend X as an alternative to X

and, when administered intramuscularly, may be used as an alternative to X.

This patient presents with X. Pain is localized to the X. Pain interferes with activities of daily living. Clinical exam findings are consistent with imaging evidence of X. Detailed evidence of a recent, X has been submitted. Under consideration is a request for X. The Official Disability Guidelines do not recommend X. Guidelines limit X to use in the X as an alternative to X, or intramuscularly as an alternative to X. There is no specific indication to support the medical necessity of a X to the X. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this X request as an exception to guidelines. Therefore, this request for X and 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)**