CASEREVIEW

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PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a X who suffers X. X has undergone X. X has undergone X.

On X, X NCV and EMG Impression: 1. X. 2. X.

On X, MRI X Impression: 1.X. These changes could reflect X. There is surrounding X. 2. X. 3.X. 4.X. 5. X.

On X, the claimant presented to X, DO for initial pain evaluation. On physical examination of the X. X had more than X. X. Temperature changes as measured by infrared thermometry on the X reviewed more than X. X had X. X had X. X. X had X. X had pain with X. Diagnosis: 1. X. 2.X. 3.X. Recommendation: X.

On X, the claimant presented to X, DO with moderate-to-severe X. Recommend X as this has been efficacious in the past. X has X. X has been highly efficacious and reduced X pain and X as well as X allowing X to be more functional and more active. X was increased to X and X was raised to X.

On X, X, DO performed a UR. Rationale for Denial: Per ODG, "In the therapeutic phase repeat X should only be undertaken if there is evidence of increased X is documented to permit participation in X. X are not a stand-alone treatment." Though the claimant has a history of X. The requested procedure is not recommended as a stand-alone treatment. As such, this request is not supported at this time.

On X, X, DO performed a UR. Rationale for Denial: The notes indicated that the

claimant had X but there was no documentation of when they were done, the percentage or duration of relief they provided, the functional improvement they provided nor it is mentioned that this current X is to be followed by X as recommended by ODG 2019. Therefore, the request for X is not medically necessary.

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

Based on records submitted and peer-reviewed guidelines, this request is non-certified. The notes indicated that the claimant had X but there was no documentation of when they were done, the percentage or duration of relief they provided, the functional improvement they provided nor is it mentioned that this current X is to be followed by X as recommended by ODG 2019. Despite what was said in the note dated X, criteria must be met prior to certification of a procedure. Therefore, 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 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)