



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
Phone: 214 732 9359 | Fax: 972 980 7836

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a X. This has been treated with X prior X. Per X last note dated X, the patient continues to have X. This has been treated in the past X months with a X. X takes pain medications, X. X has had X. On exam X is diffusely tender in the X. X has X. X has a positive X. X has X. X has decreased X. X from X. The current request is for a X.

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

Per ODG references, the requested "X" is not medically necessary. Per the ODG guidelines, X should only be indicated for X. Per the available notes, there is no objective support of or mention of a diagnosis of a X in this patient. There is also no mention of plans for an X as a possible future option. Given these factors and that there has been no new information since prior non-certification, I support the prior decision that the current request be non-certified.

**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 KNOWLEDGE BASE



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- AHCPR- 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