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**PATIENT CLINICAL HISTORY [SUMMARY]:** X who presents with X pain. X has persistent pain along the X and X provider is requesting X. X insurance company is denying the request.

X– X Report-X, MD:X:X. Exam: X of the X. Comparison: None. Findings: X. Mild X.X: Prior X seen in the X. Post contrast images demonstrate contrast extending beneath the X. There is no evidence of a X. There is no X. No X.X: Long X is intact and normally positioned. X: X is normal. X. No X identified. X. Extra-X: X demonstrates no evidence of X. Remaining X are unremarkable. Impression: 1) No X identified. X is present and contrast extends into the X but there is no evidence of a X.

X– X Report-X, Radiologist: Exam: X. X: X pain. Office Visit: X pain with loss of X.X. Patient referred for X. Exam: X arthrogram. Comparison: None. Interpretation: X of the X was unremarkable. Impressions: Successful X.

X– Physician Notes-X, MD: CC: Follow up: X pain. Assessment/Plan: The pt presents for f/u eval of X. X is persistently having symptoms of pain especially along the X. X feels this is causing increased X. Exam does demonstrate limited X. X does have X along the X. Passively, X gets to approximately X degrees short of X. X does have X. The MRI demonstrates findings consistent with a X. Discussion/Plan: X was carried out with the pt regarding the nature of X problem with X case manager was present as well. It is a difficult situation. X did undergo X. Even though X did have an X, I do feel the X is compromised. At this time, I would recommend X. This may require supplementation with a X as well as my recommendation for X. I do feel that this is more related to X and the environment for that. We are having continued X to maintain X, avoid X at the present time. X was given a refill of X and precautions were discussed with X in this regard. We also gave X to apply along the X. We will proceed with scheduling X once

approved. 1) X pain: Pain in unspecified X-X; 2) X; 3) X, not specified as X.

X- Physician Notes-X, MD: CC: Follow up. X: X present for f/u eval of X. X persistently has symptoms of pain along the X. We are awaiting clearance to undergo X. Physical Exam: X. X does have X. X directly on the X with pain with X. X exams are X. Assessment/Plan: 1)X; 2) X pain; 3)X. Discussion Notes: I previously define the treatment plan and would recommend X as noted. This was discussed with X. Likely X will require just a X. We will proceed once clearance has been obtained. X would very much like to do so given the extent of X discomfort.

X- URA Determination-X, MD:X. has been asked to review the service(s) below for medical necessity only. We decided that the services or treatments described below are not medically necessary or appropriate. This means that we do not approve these services or treatment. This is not a notice of coverage or guarantee of payment. Requested: X. Denied: X. Principal Reasons for the Determination: ODG X Guidelines indicate that X is not recommended as an X since best-evidence regarding long-term clinical outcomes for X has consistently been no better than X. Per this review, the records were reviewed, and a peer discussion was attempted regarding the requested X. In this case, the patient previously underwent X and continues to have pain with X. There is an MRI (date unknown) consistent with a X. The date of X is not documented in the review and the number of X the patient participated in is not available for review. Although the patient may benefit from X, if the patient is still having difficulty after compliance with a X, the ODG does not support the use of X as requested. As such, the requested X is not medically necessary currently and is non-certified. Clinical Basis for Determination: All the listed records were reviewed. The patient is a X individual who sustained an injury on X. The mechanism of injury was not documented in the medical reports submitted with this request. The patient was diagnosed with X. Prior treatment included X. The X. The pt's current meds are X. According to the office visit dated X, the MRI of the X. According to the office visit dated X, the patient presented for follow-up evaluation of the X. The pt persisted having symptoms of pain along the X. On examination, the pt had X. There was X directly on the X. The X exams were intact. The treatment plan included, the pt would require X.

X- Physician Notes-X, MD: CC: Follow up. X: X presents for follow up evaluation. X

is persistently having symptoms of pain in X. We have been concerned about a possible X which is persisted. They are awaiting a peer to peer call. Limited X. Does get good X noted. X exam and does have some X. Assessment/Plan: 1) X; 2) X pain; 3) X. Discussion Notes: Thorough discussion was carried out with X and X case manager regarding X condition. Given X persistence of pain. We have recommended consideration of X. Certainly any treatment would be based on X findings, this was discussed with X. We will see X back in clinic once the X has been approved. Work restrictions previously been identified. X may continue X on X own with which X is doing relatively well.

X – URA Re-Determination-X, MD: X has been asked to review the service(s) below for medical necessity only. This is not a notice of coverage or guarantee of payment. This is not an approval for a provider that is not in the patient’s network to perform services. If a provider is not in the network, the provider must have additional Out of Network approval from the network or payment may be denied. Requested: X. Denied: X

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

The request for X is denied.

This patient underwent X. The X demonstrated no evidence of X. The treating provider identified a X. X has recommended X.

The medical necessity of this procedure is not fully documented. It is unclear what are this patient’s X, which would require x. According to the x office note, the patient does “x.” Furthermore, X is not supported by the ODG.

The recommended 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)