Matriarch
CONSULTING SERVICES

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PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a X. X was taken X. X spent X month in the X. Afterwards X spent X. The claimant had X. The claimant also had completed X. No date or time phrase as to when X. X mentioned causing X. The claimant is using X. Medical report dated X by Dr. X revealed the claimant reports increased X pain and no new injury. The claimant reports medications are helping. Taking X and continues to report X. The objective findings include X. Pain was reported with X. X testing was negative. X was positive for X pain. The claimant was diagnosed with X. Dr. X reported as a result of a X, the claimant will be X. The request for X was denied twice on X treatment history to appropriately apply ODG guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
According to Official Disability Guidelines (ODG), X is recommended. The treatment recommended is for X. However, there is no documentation of prior history of X provided or response to prior X documented. Therefore, based on the review of records submitted, the request for X is not medically necessary and the prior denial is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:
Official Disability Guidelines (ODG), Treatment Index, 17th Edition (web), 2019, X Chapter:
X ODG X Guidelines:

Allow for X (from up to 3 visits per week to 1 or less), plus active self-directed X.
Displacement of X:
Medical treatment: 10 visits over 8 weeks;
X treatment: 1-2 visits over 1 week;
X: 16 visits over 8 weeks;
X: 24 visits over 16 weeks**.**