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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X whose date of injury is X. The mechanism of injury is described as a X. According to the Encounters and Procedures by X, MD dated X, X presented with continued X pain despite ongoing and aggressive X (X). X stated X lacked X (X). X was taking X for pain. X had been in continuous X and had been faithful with X. X has had treatments by the X and has tried X as well. X continued to have pain and limitation at the front of X. X had X MMI and was told by that doctor that X had a X and that X was too X like this and X. On physical examination of the X, the X showed X degrees on X. X test was positive. X and negative X were negative. X was X. X was given an X. It was noted that X had a X by Dr. X on X; however, the operative report was not submitted for review. According to the Encounters and Procedures by X, MD dated X, the patient came in for a follow-up on X. X presented with continued X pain despite ongoing and aggressive X. X stated X lacked X. X was taking X for pain. X had been in continuous X and had been faithful to X (X). X continued to have pain and limitation at the X of X. X was given X weeks before this visit and X stated that it lasted for X weeks. On review of systems, X reported X pain but reported no X. There was a lack of X. X BMI was X. On physical examination of the X, the X showed X degrees on X, X degrees on X. X test was positive. There was X of the X.

X and negative X were negative. X was X. It was noted that x-rays were examined. The X was present and properly X. The X was X; however, there was no actual imaging report submitted for review. Per the assessment, the patient was displaying signs of the X. X was recommended to get a X. The current medications included X. Office visit note dated X indicates that the patient presents for follow up of closed X. Current medications include X. The patient reports continued X pain despite ongoing and aggressive X. The patient states X lacks X. On physical examination X is X, X degrees, X. X is to the X. ER to X. X is positive. There is X of the X. X is negative. The patient is X. The initial request for X was non-certified noting that per evidence-based guidelines, X should be considered when X is

contraindicated due to X. In this case, the patient presented with continued X pain despite ongoing and aggressive X. X continued to have pain and limitation at the X. On physical examination of the X, the X degrees on X, X degrees on X to the X, X. There was positive X. There was X of the X. X was recommended to get a X. However, there were limited findings presented that the patient had a contraindication for X. In addition, it was noted that x-rays were examined, the X was present and properly X, and the X. However, there was no actual report submitted to support the information. There were no actual initial radiographs presented prior to necessitating the need for further imaging. There were no exceptional factors noted. The denial was upheld on appeal noting that per evidence-based guidelines, X are contraindicated due to X. In this case, the patient presented with continued X pain despite ongoing and aggressive X. X stated X lacked X. On examination of the X, X test was positive. There was X of the X. X and negative X were negative. X was recommended to get a X. However, there were limited findings presented that the patient had a contraindication for X. X-rays showed that the X was present and properly X, and the X. However, there was no actual report submitted for review. Furthermore, there was no actual prior radiograph submitted prior to considering a more advanced imaging. Lastly, there was no laboratory report submitted to validate the patient's X clearance as the request included X.

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

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. The initial request for X was non-certified noting that per evidence-based guidelines, X is contraindicated due to X. In this case, the patient presented with continued X pain despite ongoing and aggressive X. X continued to have pain and limitation at the X. On physical examination of the X, the X degrees on X, X degrees on X, X. There was positive X. There was X of the X. X was recommended to get a X. However, there were limited findings presented that the patient had a contraindication for X. In addition, it was noted that x-rays were examined, the X was present and properly X, and the X. However, there was no actual report submitted to support the information. There were no actual initial radiographs presented prior to necessitating the need for further imaging. There were no exceptional factors noted. The denial was upheld on

appeal noting that per evidence-based guidelines, X. In this case, the patient presented with continued X pain despite ongoing and aggressive X. X stated X lacked X. On examination of the X, X test was positive. There was X of the X. X and negative X were negative. X was recommended to get a X. However, there were limited findings presented that the patient had a contraindication for X. X-rays showed that the X was present and properly X, and the X. However, there was no actual report submitted for review. Furthermore, there was no actual prior radiograph submitted prior to considering a more advanced imaging. Lastly, there was no laboratory report submitted to validate the patient's X clearance as the request included X. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines note that X is not recommended except when X are not available or contraindicated. The submitted clinical records fail to establish that X are not available or are contraindicated for this patient. When treatment is outside the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES