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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X who alleges injury on X when X was X.

On X, the patient was seen by X, M.D., at X for a follow up visit. The claimant complained of X pain. X reported that the X pain was better than the previous visit. The pain was better on some days with X and worse on others with X. X was concerned about the X on the X that X noticed X. X reported that overall, the X pain had decreased, and the X pain and X remained the same. On exam, decreased X distribution persisted. There was X more suggestive of a X. X-rays of the X were negative for possible X. A X of the X showed X, likely representing a X, soft tissue X along the X. The diagnoses were unspecified X. The patient was recommended to continue X (X). X was prescribed. MRI of the X was ordered. The patient was referred to X. X was placed on X.

X, the patient was seen by X, M.D., for X. X sustained a work injury to the X. X. X had more pain with X. X underwent treatment with X. X of the X showed X. On exam, there was X. X was noted over the X. was positive. There was X consistent

with X. The X degrees and X degrees, respectively. The diagnoses were other internal derangements of the X. The patient was recommended X with use of X devices and X. X was prescribed.

On X, and X, preauthorization request for X was documented.

Per Utilization Review dated X, X, M.D., the request for X with use of X devices for the X as an outpatient related to X due to internal derangements of the X between X and X was denied on the basis of the following rationale: "*The claimant is a X with a reported date of occupationally related injury on X. The mechanism of injury is reported as a X. Clinical evaluation on X notes the patient complaints of X pain and X. A pain level of X on the X is noted. Symptoms were noted unchanged. Previous treatment had indicted X. The exam on that day noted blood pressure was X, pulse X, height X" and weight X lbs. The X exam that day noted normal X, no obvious X , no X. It was noted there was no actual X, but X was more suggestive of X. There was no X. A X on X was noted to show a X. There were recommendations to continue X. A clinical evaluation on X noted the complaints of X pain and X and more pain with X. The exam, this day noted antalgic X, tenderness at X, positive X. The soft tissue swelling/mass over the X were noted. The diagnoses included X. There was a recommendation for X. X. Understanding that the request for surgery is not supported, the requests for X, are not necessary. There are not medically necessary for this request.*"

A correspondence from X dated X, notified Dr. X about the denial.

Per Reconsideration dated X, by X, M.D., the request for X, was denied based on the following rationale: "*The claimant is a X -year old injured on X. The mechanism of injury is reported as a X. An office visit on X presents with a chief complain of X. Previous treatment includes X. The exam this day noted antalgic X, X , positive X. The soft tissue swelling/mass over the X were noted. The diagnoses included internal X. There was a recommendation for X. Previous note dated X documented that the patient complaints of X pain and X. A pain level of X on the X is noted, Symptoms were noted as unchanged. Previous treatment had included X. The physical examination of the X revealed normal X, and normal X, no X, normal X. It was noted there was no actual X , but X was more suggestive of a X. There was no X. There*

were recommendations to continue X. A X MRI on X was noted to show a X. The ODG does not support the use of a X following X. There is no rationale provided for why a X would be necessary. In addition, as X is not medically necessary, the X is not medically necessary. The ODG supports the use of X for patients with X impairments. However, as X is not medically necessary, the X are not medically necessary. The ODG does not recommend the home use of X. There is no evidence of a X. In addition, as X is not medically necessary, the request for X is not medically necessary."

A correspondence dated X notified denial to Dr. X.

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

Based on the documentation provided, as well as the rationale of the two preauthorization reviewers, the NONAUTHORIZATION of the requested procedure (and associated requests) appears to have been appropriately formulated by each reviewer. The reviewers denied the authorization based on the lack of indication for the surgery, and the lack of necessity of the items requested to provide the surgery.

The procedure does not appear to medically reasonable or necessary and does not fit into any ODG criteria, as no ODG criteria are published pertaining to surgical management of soft tissue X. The symptoms are nonspecific to a X. The physical exam findings did not reveal anything more than something "suggestive" of a X. The MRI identified a relatively small and likely X. There is no reasonable rationale apparent for surgically managing the X, and no evidence-based literature support provided by the requestor to bolster X recommendation. There are recognized complications from X; the requestor has failed to address the risk: benefit ratio. From the evidence provided, the risks appear to outweigh the benefit.

☐ Medically Necessary

X Not Medically Necessary

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES