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PATIENT CLINICAL HISTORY [SUMMARY]: X who presents with a X. X provider is requesting X that X insurance keeps denying.

X – Imaging Results-X, MD: MRI X. Hx: X pain after injury. Acute timeframe. X. Initial encounter. Comparison: MRI X dated X. Impression: 1) No evidence of X identified. 2 X.

X– Physician Progress Note-X. MD: Chief Complaint: X pain. HPI: The pt is a X who presents with a X pain. The current X. The Pt states that X symptoms developed suddenly while X. X also reports X. The Pt denies X. Previous treatments: X #3. –On X: Pt states X is still having pain and X. Pt denies X. Pt states X is out of pain medication. -X: Pt returns for f/u X pain. X reports continued X and pain that has not improved. X has completed X. X reports X on X did not help at all. X is taking X for pain. –X: Pt is here today for a f/u appointment of the X. Pt reports continued X. X has completed X as of X. X current pain is X. X saw Dr. X for a second opinion on X. -X: Pt is here today for X f/u. Pt states X pain is unchanged. X continues to have moderate pain and X. X states X was denied because WC is only accepting a X. X is taking X for pain. Assessment :X, initial encounter. Plan: Orders: Med Report

W/C. Instructions: Risks and benefits of X vs. X of the Pt's condition was discussed in detail. Pt has exhausted all X means that we can provide for X under a X. I advised the Pt that X next step seeing that the X was denied would be to refer X to X. F/U in X weeks.

X– Physician Notes-X, DO: HPI: At work, X. X has had X, X consultation. X pain is described as an X pain, varies in intensity from X on a X score. X: Negative. Past X History: Positive for X. Review of Systems: Non-contributory. Physical Exam: On examination, X has negative X. The X. The X is taught and non-tender. X has marked X over the X. X certainly has a X of the X. The X shows definite evidence of X. Clinical Impression: 1) X secondary to injury of the X; 2) Rule out X. Recommendations: I believe this pt will benefit greatly from X and I am recommending X for X as quickly as possible. I would like to reevaluate this Pt's X after X has been in X weeks.

X– Physician X Assessment-X, Ph.D.: Background Information: X who was referred by X treating doctor for evaluation to assist in determining if X is an appropriate candidate for an X. X presented with X pain resulting from a work-related injury. X described X pain as an X. Med and X: X med hx is positive for X. X in unremarkable. Treatment Hx: Previous treatments for the injury include X. Prescribed Meds: X. X Use: X reports infrequent and limited use of X. X usage of X per day is reported. X denies any use of X substances. X Test Results: X test results suggest X is preoccupied with healthcare concerns and reports high pain levels that X perceives as X. X reported a high level of X with moderately high perceived impairment in X. Contributing further to the current presentation is a significant X that activity is harmful and pain associated with increased activity is likely causing damage. Pain X is likely. Summary and Recommendations: X is an appropriate candidate for an X that focuses on X. X presents with X pain, significant X. X coping skills are indicated. Treatment goals should include increasing X. In addition, treatment should focus on increasing X. X motivation for a X approach was explored and X appeared appropriately motivated verbalizing an understanding that treatment was not focused on pain relief but rather X, reducing dependency on meds and the healthcare system and return to a more independent lifestyle.

X–X Evaluation-X, P.T.: A X evaluation was performed in order to gain baseline

data. The purpose of the eval was explained to the pt who was instructed to give a genuine effort X: The Pt is X who was involved in a work-related injury. The Pt X. Following the injury, the Pt received the following treatments: X (no evidence of X), X. The Pt reports complaints of X. These symptoms are made worse with X. These symptoms are made better with X. X current pain is X. Pain level at worse: X; pain level and best: X. Past medical X includes X. Current prescription meds include X. Brief job description: X worked for X at the time of injury. X had worked X years in X. X is currently not working due to injury; but wishes to return. X job activities would require X to spend X of X. Frequent (X of the day) activities X was required to perform included X. Less than X of the day X was required to X. The max weight lifted was X lbs. Impressions: The pt presents with fair endurance during testing. During testing, the pt appears to be putting X. X were demonstrated during most testing procedures. The Pt demonstrated X. This was determined when the pt demonstrated the ability to X. The pt's job is classified in the X category. Recommendations and Goals: Based on todays' eval the pt has demonstrated significant X but has also displayed good rehab potential. The Pt has a X of treatment without significant relief of symptoms or improvement in overall function. X would benefit from an X that addresses issues related to X, X.

X– Physician Letter- X, Ph.D.: Attention Preauthorization Department: Please accept this as a request for preauthorization of a X. Consultation with the evaluation team has occurred and has resulted in agreement with the current treatment proposal. There is not currently any plan for X and X has exhausted all other appropriate primary and secondary treatments. The proposed X will focus on X. The patient has undergone the following primary and secondary levels of X. Impaired Level of X: The patient's level of pain interferes with X ability to X. X resulted in a measured X category. The patient meets the following criteria in X : X is greater than X months duration with physical findings; the patient has failed to respond to X levels of care; X pain is not purely X in origin; the patient exhibits severe X; X pain has persisted beyond the expected tissue healing time; X impairment is greater than expected on the basis of X diagnosed medical condition; X is facing a significant loss of functioning that requires a major X ; and X is not a candidate for further . I am requesting a X. I believe X clearly exceed the minimum criteria for determining reasonableness and medical necessity of the requested treatment. If further information or clarification is needed, please

contact me.

X– URA Determination-X Utilization Review: This correspondence pertains to the review of the following health care service(s). After peer review of the medical information presented and/or discussion with a contracted Physician Advisor and the medical provider, it has been determined that the health care service(s) requested does not meet established standards of medical necessity. This review applies only to the specific service(s) listed below. Any additional service(s) will require a separate review process. Specific Request: **X. Physician Advisor Decision Date: X. The above review was made based on guidelines which are developed from acceptable standards of practice as recommended by medical specialty societies, the latest evidence from published research, federal agencies, and guidelines from prominent national bodies and institutions.

X– Physician Letter-X, Ph.D.: Dear Sir or Madam: I am requesting reconsideration of your recent preauthorization denial of treatment for X in an X. The reason for the denial is based on a peer review in which the reviewer's concluded that "there is no evidence the claimant has exhausted all X care treatment options available." The reviewer then suggests that X are the treatments in question. It should be understood that the relevant ODG criteria is as follows: *Previous methods of treating X have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. X* has undergone X to date with very limited benefits. The recent X reveals substantial X in areas of X. Regarding X, as noted by the reviewer, X has had X. X reports no benefit which is documented in Dr. X notes. Furthermore, X underwent evaluation with Dr. X, a pain management X in which he made no recommendation for X. At the present time none of healthcare providers working with X have recommended X in question. Based on the ODG criteria as well as other published and recognized guidelines and criteria X appears to meet all requirements for determination medical necessity of the requested X. I have resubmitted all the previously submitted material for your review including the referenced X. Should you have any questions or concerns regarding this request please contact me.

X– URA Re-Determination-X Claims Management Services, Inc.: This correspondence pertains to the review of the following health care service(s). As

requested, a second contracted physician who was not involved in the original non-certification has reviewed the original information, supplemented by additional medical records submitted and/or peer discussion(s) with the treating provider. The second physician has upheld our original non-certification. Specific Request: **X. Physician Advisor Decision Date: X. The above review was made based on guidelines which are developed from acceptable standards of practice as recommended by medical specialty societies, the latest evidence from published research, federal agencies, and guidelines from prominent national bodies and institutions.

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 injured X. X has completed a course of X. X MRI (X) was unremarkable for an X. The treating provider has recommended an X.

Before considering this program, the patient should complete a MR-arthrogram of the X, which may have been missed by a standard MRI. X should also complete X condition. A second X may also be helpful for X.

The requested program is not medically necessary now.

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)