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PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was allegedly injured at work X. The date of injury was X. The patient was evaluated by Dr. X on X complaining of X pain. The patient apparently underwent X immediately following the injury, which only helped mildly. X apparently was then seen by Dr. X and underwent a X with improvement of pain for X. X presented to Dr. X complaining of X. Dr. X noted an MRI scan (no report made available) that allegedly demonstrated X. Dr. X made no mention of any X. Physical examination documented a non-specific X test with non-specific X. There was X. X were X. Initial pain level was X. Dr. X then performed X on X and followed-up with the patient on X, reporting a pain level of X with ongoing X pain and occasional X. Dr. X stated that the patient stated that the intensity of X pain was “markedly improved,” but still complained of “X.” No physical examination was documented. Dr. X recommended continuing X and referred the patient for X treatment and prescribed X.

Dr. X followed-up with the patient on X, noting X same pain level as X and same complaint of X pain with occasional X in the X. Physical examination documented a non-specifically positive X test, the same mildly diminished X. Dr. X recommended continuing X as well as X care and recommended another set of X. On X, Dr. X repeated X. X followed-up with the patient on X, reporting a pain level of X and the patient's report of "marked improvement in X pain." The patient no longer had X pain, but still had persistent X intermittently. The patient also "denies any residual X pain." Physical examination did not document any abnormalities. Dr. X stated that the patient had X improvement. X recommended continued X, as well as an X to evaluate return-to-work status. On X, the patient returned to Dr. X with a significantly increased pain level of X after having returned to a "new job" over a month before which required "marked heavy lifting." The patient did not complain of X pain, but still had slight X, but did complain of increased X pain. Physical examination documented positive X only. X recommended a X, as well as continued X as well as diagnostic X. X stated that the previous MRI scan demonstrated X, despite having made no mention of that finding in any of X previous progress notes nor providing any copy of that MRI report. On X, Dr. X performed X. The patient returned for follow-up on X, reporting a pain level of X (was X prior to procedure) and approximately X hours of X improvement in pain. Dr. X had previously indicated that a X procedure would be considered if the patient sustained X relief of pain in X prior progress note. Two subsequent physician advisors recommended non-authorization of the request for X based on the ODG. Dr. X followed-up with the patient on X, noting X ongoing pain level of X. X did not document the patient's pain complaint, nor did X indicate whether the pain was strictly in the X or X. X again noted that the patient had undergone X immediately post injury as justification for exhaustion of X treatment. X again requested X

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

It appears that the patient had successful resolution of the pain associated with the work injury of X after X sets of X by Dr. X. X had recurrence of X pain only after returning to a different job that required heavy lifting some X weeks after returning to work. There is no documentation on an MRI report of the patient having X. There is also no documentation provided of a X of X treatment, including X. Additionally, although Dr. X set a goal of X pain relief to justify doing X, the patient did not attain that goal and more importantly, the duration of the alleged relief following the X (approximately X hours) was less than the expected duration of the X Dr. X used, which was X. Therefore, not only did the patient's response not reach the degree of relief Dr. X set as a criterion for proceeding with X, the duration of relief did not even meet the duration of the X. The ODG notes the criteria for use of X includes treatment that required a solid diagnosis of X pain confirmed by a X with a response of X for the duration of the X, which is not the case for this patient. Therefore, the requested X is not reasonable, medically necessary, or supported by the ODG based upon the patient not getting a duration of relief even equal to the X nor a degree of relief sufficient to justify performing X per the requesting doctor's own criteria. Therefore, the previous adverse determinations are upheld at this time.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY 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)**