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PATIENT CLINICAL HISTORY [SUMMARY]: X with a date of injury X. X was working as a X. X stated that the X. By instinct, X tried to X, which caused a X. X felt X into X and X. X was diagnosed with X. On X, X was evaluated by X, MD for the X pain and to follow-up on an MRI. The pain was rated as X. The X examination showed pain and X of X, pain and X of X upon X, X tests were positive. The X active X showed X degrees, X degrees, X degrees, X degrees, X degrees, and X degrees. The X degrees, X degrees, X degrees, X degrees, and X degrees. The XX was X at X. X-ray of the X dated X showed X. X-ray of the X dated X showed X. A CT scan of the X dated X revealed X, there was an X projecting fairly from the X which resulted in X. Those X could also cause symptoms of X. X noted. Treatment to date consisted of X. Per Utilization Review Determination letter dated X by X, MD, the request for X was denied. It was determined that X was status X performed in X. While X reported ongoing X pain, there were no updated imaging studies noting significant X that would be considered X. No significant X was noted on prior X. Further, the records did not document a recent evaluation of X. The prior evaluation was more than a month old. Given those issues, which do not meet guideline recommendations, Dr. X could not recommend certification for the request. A letter dated X by X, MD indicated that the reconsideration request was non-certified. There was a prior determination, which stated that there were no updated imaging studies noting significant X that would be considered X. There

was no significant X noted on prior X. There were no additional documents that clarified the condition. The objective response from all indicated X treatments prior to the consideration of the request could not be fully established. Exceptional factors were not clearly identified. Multiple attempts were made to contact the surgeon to garner additional information or exceptional circumstances, which was unsuccessful. Therefore, based upon the provided documentation, the request was not currently supported.

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

The ODG recommends a X for the treatment of X when there are limited functional demands, pain has not responded to at least X months of X therapy, there is adequate X, there is adequate X, there is X. The provided documentation reveals evidence of X pain greater than X years old from injury despite treatment with X on X, X sessions of X, and X sessions of X. A CT scan from X revealed X as well as an X. There is no documented superior migration of the X on the CT scan radiology report to suggest there is a X and there are no postoperative MRI results documenting and X. Based on a lack of imaging findings consistent with an X is not medically necessary.

Given the documentation available, the requested service(s) is considered not medically necessary. Therefore, the request is upheld.

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

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL