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PATIENT CLINICAL HISTORY [SUMMARY]:

X: Office Visit by X, FNP-C. **HPI:** X was working with X on X. X was examined the next day. X pain. EMG showed evidence for X. X was referred for probable X. The patient meets all X. It is medically necessary at this time to proceed with X, then based upon X response further X may be necessary.

X: UR performed by X, MD. **Rationale for Denial:** The claimant is X. Over time, X developed X. X continues with subjective complaints of X. Objective findings note X provided. A X is requested. The guidelines require that specific criteria be met prior to X. Considering that there has not been X evaluation of lab studies. In that, this criteria has not been met, the request is not supported. The request for X is medically necessary.

X: Letter of appeal by X, FNP-C. Please reconsider your denial for X.

X: UR performed by X, DO. **Rationale for Denial:** Based on the documentation provided and per the ODG guidelines, the requested appeal for the X is not considered medically necessary at this time. Thought the claimant has a history of X. As such the request is not considered medically necessary at this time. Based on the documentation provided and per the ODG, the requested X is not considered medically necessary. Given the claimants history, the requested X is considered medically necessary in this case, but I was unable to contact the provider and due to this being a X case, it's an all or nothing approval or denial. As such, the request is not medically necessary at this time.

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

Based on the documentation provided and per the ODG guidelines, the requested

appeal for the X is not considered medically necessary at this time. Though the claimant has a history of X. Per ODG, X is required prior to X. A X is requested. The guidelines require that specific criteria be met prior to X. Considering that there has not been X. In that this criteria has not been met, the request for X is not supported until the X has been completed. The request for X is medically necessary.

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 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
- 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)