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PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X was working on an X. X was diagnosed with X. On X, X visited X, DO for a follow-up of X pain. X had undergone X. X stated that X had more than X. The X pain was constant with X. It was described as X. The symptoms would occur continuously. The pain X. The aggravating factors included X. On examination, X was noted. There was X over the X. X had pain with X. The X was painful on inspection. X test was positive on the X. The X was painful. The X was X. There was X. An MRI of the X dated X showed X. At X, there was severe X. At X. The treatment to date included medications X on X. Per a utilization review decision letter dated X, the request for X was denied by X, MD. Rationale: "Per evidence-based guidelines, X should require documentation that X. In this case, it was mentioned that the patient reported significant X. X reported greater than X percent relief for X. X reported X pain was similar to what it was prior to the X. X continued complaining of X. It was mentioned that it was consistent with the X. X had decreased X. A request for X was made. However, medical records were limited for comparative evaluation of findings to objectively validate at least X percent pain relief and improved function from the X prior to the consideration of a X. Objective X was not established as there was X. There was no documentation of X. Also, as the guidelines state, X is X. There should be evidence of X in association with X. Exceptional factors were not identified." Per an adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: "The previous non-certification was supported. Additional records were not submitted for the review. The guidelines require X pain relief with a previous X including improved function for X weeks prior to a X. There should be an objective evidence of X. The MRI reported no evidence of X. There was X. The claimant had only X percent relief for X after the previous X. The request for an appeal of a X was not certified." Furthermore, the primary reason for determination included X.

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

Official Disability Guidelines discusses indications for X. X may be indicated in the presence of a X. The medical records in this case do not document such findings at a X. Moreover, as discussed in the prior review, the patient's response to a X was limited; the rationale or indication for a X in such a situation is not apparent. Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

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

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES