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**PATIENT CLINICAL HISTORY [SUMMARY]:**

X who was injured on X at work. X was X. X tore a X. X had X. X was diagnosed with a X. On X, X was seen by X, MD for X. The pain X. X was X. The pain was described as X. The aggravating factors included X. It had been worsening to the point that X. X examination showed X. X test was X. There were X. X had pain in the X. Diagnostic X was requested. On X, X complained of X pain X. The pain was rated X. Per the note, the X had been denied. On X, the X pain was described as X. On X, X returned for X pain. The pain X. X was X. The pain was described as X. The relieving factors were noted as X. On examination, X had X pain on X. X had X. X was evaluated by X, PhD on X. X reported the primary location of X pain was in the X. X reported the pain was X. X was experiencing pain since the injury and described it as X. X reported an average level of pain at X. The X work scale was X, and the activity scale was X. In summary, the pain was resulting from the injury and had X. X reported X. X had reported X. On X examination, X was X. X content was X. It was noted that X would benefit from a course of X. It would improve X ability to X. X should be treated daily in a X. The program was staffed with X. The program consisted of, but was not limited to, X. These intensive services would address the X. Without this type of X, X and thoughts were likely to continue in a X. It was crucial that X receive other necessary components, which were not provided in X, to help obtain the tools needed to succeed. X-rays of the X dated X showed X. An MRI of the X dated X demonstrated X. There was no X. Multilevel X. X were noted. Treatment to date included medications X.

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

Based on the clinical information provided, the request for X is not recommended as medically necessary. Office visit note dated X indicates that the

patient was released from care as maximum medical improvement was reached for the patient's injury(ies). The patient was determined to have reached maximum medical improvement as of X. Office visit note dated X indicates that the patient reports that X never got X. X that X received was for X X. Note dated X indicates that the patient's case has been reopened. The patient continues to complain of X pain. The Official Disability Guidelines note that X are limited to patients with X. The submitted clinical records indicate that the patient presents with X. Per note dated X, the patient was recommended for X. The patient's X - mediated pain. There is no documentation of a course of X for treatment of the patient's X. The current request is nonspecific and does not indicate the level/laterality being requested.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

**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