CASEREVIEW

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PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a X who was injured on X while X. X originally was treated with an X. Later X was seen by X PCP and given an X. X completed several sessions of X.

On X, MRI X Impression: X.
On X, the claimant presented to X, FNP-C with X that were described as X. X reported X. The pain was relieved by X. Exam: X is X but X. X. Palpation over the X. Palpation over the X. Palpation over the X. Palpation of X. X is X on the X. Pain is worsened by X. X test is X for pain in the X. X referral pain pattern is noted. X test is X. DTR: X. Assessment: 1. X, 2.X, 3. X, 4.X, 5.X, 6.X. Plan: prescribe X, refer to Dr. X for evaluation and consideration of X.

On X, the claimant presented to X, MD with X. On exam X was X. X were diminished in the X. X was X. X. Plan: X. If X is successful, X, followed by X will be requested.

On X, the claimant presented to X, MD with continued X pain rated X. Recommendation of X. It was reported that the claimant has a degree of X about X. It was communicated the importance to minimize sudden movement during the procedure. Therefore, the claimant communicated willingness for X during the procedure.

On X, X, MD performed a UR. Rationale for Denial: In the clinical records submitted for review, the examination of the X revealed X. X testing was X. No documentation of X would warrant the use of X. There was a pain in the X. An MRI of the X performed on X with an impression of X. Although the request for X. Therefore, due to the request for X, the request is non-certified.

On X, X, MD performed a UR. Rationale for Denial: As noted previously, although the requested X procedure is supported, given that the request included procedural terminology (CPT)X, requesting X during the procedure, the request in its entirety cannot be supported. There was no indication that the patient suffered from X to support the need for X during the requested X.

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

Based on records submitted and peer-reviewed guidelines, this request is partially certified. The requested X is medically necessary. There was no indication that the patient suffered from X to support the need for X during the requested X. Therefore, though the procedure is supported and medically necessary, the associated X is not supported, nor 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 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
- ☐ PRESLEY 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)