CASEREVIEW
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PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a X.

On X, Procedure Note by X, MD: Postoperative Diagnosis: 1. X. Procedures Performed: 1. X. 2. X–x-rays.

On X, X, 2 views: Impression: 1. Status post X. There is X. The X. There is X. 2.X. 3. No other X. 4. X are noted.

On X, the claimant presented to X, MD status X. X was X. Reported X in X. The claimant X. Medications: X. Exam: There was X. X had X. Plan: Progressively X. Obtain a X.

On X, X, 2 views: X. The X are in X. There is a X. No significant X is noted.

On X, the claimant presented to X, X without assistance. X had X. Plan: Progress X.

On X, X, 2 views: Impression: Progressive but incomplete X.

On X, the claimant presented to X, X reporting that after medication given on previous visit, X. X still had a lot of X. On examination X had X. Plan: Progress X. Recommend obtaining a X.

On X, X: Impression: 1. X. There is X. 2. Incompletely X.

On X, the claimant presented to X, MD reporting that X had X. Medications: X
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On X, X, MD performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per guidelines, X are not recommended. There is X to support the use of X. While X is also not recommended for routine X. Not recommended solely to protect against X. Although X is commonly performed, it should be considered a routine procedure. In this case, a request is for X was made; yet, the guideline does not support the request. Clear exceptional factors were not identified. As for X is under study. X has been used for X. Medical report submitted had limited subjective complaints and significant objective findings to warrant the need of the request. In addition, X is considered experimental due to lacking high quality evidence of efficacy. Thus, the request is not support.

On X, X, MD performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per guidelines, X are not recommended. There is inadequate objective clinical evidence to support the use of X. While X is also not recommended for routine X. Not recommended solely to protect against X. Although X is commonly performed, it should be considered a routine procedure. Therefore, the request is for X is not supported. There were X, therefore this remains not medically necessary.
As for X is under study. X has been used for X. Medical report submitted had still limited subjective complaints and significant objective findings to warrant the need of the request as there was no recent progress report submitted. In addition, X is considered experimental due to lacking high quality evidence of efficacy. Thus, the request is not support.

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

The request for X is not medically necessary.

This patient sustained a X. X was treated with X. X has developed a X. The treating physician has recommended X. X have adequate vascularity to heal, but do not

have sufficient stability. X is usually not required for X. This case will require X. Therefore, the recommended surgery is not 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)