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PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is X who was injured on X, when X.

On X, the patient was seen by X, PA-C, for evaluation of the X. The patient was seen at X and diagnosed with X. The patient was put in a X. The pain was rated at X in severity. The symptoms were described as X. On examination, the X had X over the X. There was a X test. There was pain with X. There was a X. X-rays of the X showed a X. The diagnosis was X. The patient was placed in a X. An X was recommended.

On X, X, D.O., performed X. The postoperative diagnosis was X.

On X, the patient was seen by Dr. X. The patient X. The patient was taking X. On examination, the X. The X test was X. There was pain with X. X was X. X-rays of the X showed plating of a X. With the patient's recent X, the X looked to be X was noted. The patient was placed in a X.

On X, the patient was seen by Dr. X. The patient reported a X. X-rays of the X showed plating of a X. With the patient's recent X, the X looked to be intact, but the X was noted and X. The X looked to be X. The patient was recommended to X. The plan was to get the patient back in X.

On X, the patient was seen by Dr. X. The patient was doing well with a X. The patient was X most of the X. Medications were refilled.

On X, the patient was seen by Dr. X. The patient was doing better with a moderate amount of pain. The patient reported the X. On examination, there was X. The X test was X. There was pain with X. X was X. There was X present. X-rays of the X showed X. The diagnosis was a X. X was recommended. Medications were refilled. The patient was recommended to be in a X and progress X.

On X, Dr. X ordered X. The diagnosis was X.

Per Utilization Review dated X, by X, M.D., the request for X between X, and X, was denied based on the following rationale: "*Per submitted documentation, the patient X. Prior treatments included X. No other treatments were documented. No diagnostic studies X was included. According to the prescription submitted by Dr. X on X, the patient was diagnosed with X. No subjective complaints, objective examination, and orthopedic testing were documented. The treatment plan included X. The Official Disability Guidelines recommend up to X. The provided documentation indicates the injured worker is X. The review documentation includes a prescription for X from X, but the most recent provided clinical progress note is from X. As such, the current subjective and objective clinical findings are known. In addition, it is unclear if previous X has been performed, and if it has, the treatment response and the X. Therefore, the request of X is non-certified.*"

On X, the patient was seen at the X. The diagnoses were X. X was recommended X. The treatment modalities would include X.

Per Utilization Review dated X, by X, M.D., the request for X between, and X, was denied based on the following rationale: "*The Official Disability Guidelines (ODG) supports X. Based on the clinical documentation provided, the injured worker underwent X. It is suggested by the X clinical note that X has not yet been initiated. On physical examination, there is X. While X would be supported for X, it is unclear what specific CPT codes are being requested. Therefore, the request for X is non-certified."*

On X, Dr. X ordered C. The diagnosis was X.

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

Based on the medical records there is no indication that the individual has completed any X only evaluation. ODG does indeed allow for X

have been requested. Based on the records for review, the diagnoses and the documented treatment rendered it is my opinion the request is reasonable, medically necessary and the decision should be overturned.

X Medically Necessary

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES