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PATIENT CLINICAL HISTORY [SUMMARY]:
X: Patient Notes by X, MD. **Subjective:** Patient history X. MRI reveals X. These changes resulting X. X. X was to have X however this was denied. **Assessment:** 1. X. 3.X. 4. X. 5.X.

X: Patient Note by X, MD. **Subjective:** Patient had X with Dr. X that helped X pain for X.X. **Plan:** 1. MRI x-rays X. 2. EMG with X. 3. Dr. X now provides X.

X: UR performed by X, MD. **Rationale for Denial:** Based on the clinical information submitted for this review and the evidence-based guidelines, the request for X is non-certified. X may be useful if there is X. It is not clear how this study would change X course of treatment. No additional documentation was submitted that would support medical necessity. In addition, no documentation was provided that would support acquiring an X. Given the provided information, this reviewer would not recommend certification for this request.

X: UR performed by X, MD. **Rationale for Denial:** The appeal for X is not medically supported. Previous peer reviews have non-certified requests for X. Moreover, X. Considering these factors overall, it is still unclear how an X study would meaningfully change the diagnosis or treatment plan in this case. This remains to be the case. No new clinical information is presented for this review that would contravenes the previous determination or the guideline recommendations. The patient is approximately X years X. The X report does not identify significant subjective or objective changes indicating X. In addition, no documentation has been provided that would support acquiring an X. Therefore, my recommendation is to non-certify the request for appeal X.

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 and is denied.

This patient X. According to the X MRI study, X has X. On examination, X has X. X. The treating provider has recommended an X.

The Official Disability Guidelines (ODG) supports X. It is not recommended for X.

This patient's X condition has remained X in the records reviewed. X has X. It is unclear how the data from an X will change X course of treatment.

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)