

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a X with a history of an occupational claim X. The mechanism of injury was documented as a X. The patient had X. The MRI of the X dated X revealed an impression of suspected X. There was X. There was X. There was a X. The patient had been treated with X. The office visit dated X indicated the patient had X. The x-rays revealed X. The diagnoses included X. The office visit dated X revealed the patient had a chief complaint of X. The pain was present for X months. Aggravating factors include X. The symptoms included X. The patient had pain with X. The pain was rated X. The treatment plan included a X.

The requested service was previously denied as the most recent progress report did not contain any X. The guidelines do not recommend requested X. The request did not appear to follow the guideline criteria.

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

The Official Disability Guidelines indicate that a X is recommended for X. Additionally, a X is usually contraindicated with any imaging presence of X. X also suggests poorer outcomes. The records indicated the patient had X. The patient had subjective complaints of X. On examination, the patient had X. The patient had X. The provider requested a X. Per the x-rays dated X, the patient had X. The guidelines note that a X is contraindicated with any imaging presence of X. The x-rays and MRI supported a diagnosis of X. In agreement with the prior denials, given the X noted in the X, the requested X is not medically necessary. The prior determination is upheld.

**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,**