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PATIENT CLINICAL HISTORY [SUMMARY]:

X with date of injury X. X was X. X began to experience X. The diagnoses were X. X visited X, MD on X for the complaints of X. X pain was X. It was rated X at X and X at its X. The symptoms X. X reported having X since X. The affected area was X of X. X reported having increased pain since the prior visit. The X had been compensable, but X reported having pain in the X. X had undergone X and had also undergone X, which had provided X. Examination of the X showed X. Full X was noted. There was X during X. The X was intact in X except X in the X. X test revealed pain with X. X sign at the X test were noted to be X. It was opined that, since X had X, request for X was made. X was seen by Dr. X on X for the complaints of X. The pain was rate X and X. X reported having X and X since X along with X. The affected area X. X reported having X. The X had been compensable, but X reported having pain in the X. X had X. The X pain was X. Examination of the X showed X. X was noted. There was X. The X was intact in all X. X test revealed pain with X. An x-ray of the X performed on X showed X. No other obvious X was seen. Per Dr. X, since X had X, appeal for surgery including X. An electrodiagnostic study of the X dated X demonstrated electrodiagnostic findings of a X. It was likely not related to the X. X was noted at the X. There were findings of a X. There were X. There were X. An MRI of the X dated X identified X. The findings were X. There was X. There was X. The treatment to date included X. A Peer Review was completed on X by X, MD. The initial request for X was noncertified. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. After speaking with Dr. X, he stated the patient has had an X. The patient X, which per the provider is not recommended by guidelines. The patient has been treated with X. The patient X. The patient has X. The patient has X. Therefore, all of the above requests are not supported." A

Peer Review was completed on X by X, MD. The appeal for X was noncertified. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Given that the patient has not had X. There were no changes made with the prior determination as it is upheld. Clarification is needed with respect to the X; that guidelines indicate that X.”

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

The ODG supports surgical intervention for X. The documentation provided indicates that the injured worker has had X which has been persistent since X without X. A physical examination documented X. An MRI documented X. The treating provider has recommended a X. Based on the documentation provided, the recommended surgical intervention would be considered medically necessary. While there is X. It is unlikely that X would result in meaningful improvement.

Given the documentation available, the requested service(s) is considered medically necessary and the request is overturned.

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

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL