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**PATIENT CLINICAL HISTORY [SUMMARY]:**

X with date of injury X. The mechanism of the injury was not available in the records. X was diagnosed with X. X visited, MD on X for the chief complaint of X. X had X. X denied any X. A recent CT X showed previous X. There were X. X reported minimal relief of X. The X was described as X noted in the X. The pain frequently X. The pain was exacerbated with X. Pain was also exacerbated with X. The pain frequently disrupted X. Pain was rated a X that day. X reported X reduction of X. Examination of the X noted a X. A X was noted in the X. X was X. On X examination, X was noted extending from the X. X was somewhat limited secondary to pain. It was assessed that X had confirmed X. X had X. On X, X presented for medication refill. Per the note, X was awaiting X. The pain in X. X reported the ongoing medication regimen provided approximately X reduction of X overall pain and an improvement in X functional capacity. X examination noted X. X produced X. X also complained of X. X was present within the X. X examination showed X. An x-ray of the X dated X showed X. A CT scan of the X dated X demonstrated X. There was X. X were present. There was X. There was X. At X was noted resulting in X. At X, there was X. At X, a X. At X, there was a X. At X, there was a X. The X demonstrated X. An X dated X identified evidence of an X. Treatment to date included medications of X. Per a utilization review adverse determination letter dated X, X, MD denied the request for X. Rationale: "The records indicate an X had been authorized, however, results of the study were not provided. The X examination findings do not support X. The guidelines do not routinely support X. The procedure should be recommended on a case-by-case basis. If performed, X should be well documented, with X. On X, an appeal letter from X, X, documented that the request was denied due to "... the records indicate an X had been authorized; however, the results of the study were not provided. If performed, X should be well documented with X." The X results had

been attached for review. An appeal determination denial letter was documented on X, by X, MD, upholding the prior denial. The following rationale was provided for the determination: “This X year-old patient sustained an injury on X and was diagnosed with 1) X, 2) X, 3) X 4) X. Per Official Disability Guidelines (ODG), "X must be well documented, along with X. X must be corroborated by imaging studies. A request for a procedure in a patient with X." In this case, there is no documented evidence X. In addition, per ODG, "X is not a standalone procedure. There should be evidence of X. This can include a X." There is no record of such a plan for X. The request is not shown to be medically necessary.”

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

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review adverse determination letter dated X, X, MD denied the request for X. Rationale: “The records indicate an X had been authorized, however, results of the study were not provided. The X examination findings do not support X. The guidelines do not routinely support X. The procedure should be recommended on a case-by-case basis. If performed, X should be well documented, with X. On X, an appeal letter from X, X, documented that the request was denied due to “... the records indicate an X. If performed, X should be well documented with X.” The X results had been attached for review. An appeal determination denial letter was documented on X, by X, MD, upholding the prior denial. The following rationale was provided for the determination: “This X year-old patient sustained an injury on X and was diagnosed with 1) X, 2) X, 3) X 4) X. Per Official Disability Guidelines (ODG), "X must be well documented, along with X. X must be corroborated by imaging studies. A request for a procedure in a patient with X." In this case, there is no documented evidence on examination of X. In addition, per ODG, "X is not a standalone procedure. There should be evidence of X. This can include a X." There is no record of such a plan for X. The request is not shown to be medically necessary.” There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient’s physical examination X.

Therefore, medical necessity is not established in accordance with current

evidence-based guidelines and the request is upheld.

**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