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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X who was injured on X, when a X.

On X, a magnetic resonance imaging (MRI) of the X performed at X, interpreted by X, M.D. The indication for the study was X injury and pain. The study showed: X. No X was noted.

On X, the patient was seen by X, PA/ X, D.O., for the X pain and to review the MRI result. The patient injured X. It X. X had no change in X pain since the onset. X had been X. The X exam was X. There was a X due to the X. The MRI result was reviewed, and it was X. The diagnoses were X. X was ordered. The patient was released to X.

On X, Dr. X noted the patient continued to have X pain. Re-examination of the X, X. X was prescribed. The X was recommended.

Per Utilization Review dated X, the request for X was approved for X to the X for dates of X, through X, at X as requested by X.

On X, the patient was seen by X, D.O., for the X pain. The pain was rated at X. X denied previous X. X had X. The examination showed a X. X-rays of the X demonstrated X. The X was in a good position with the X. There were X. There was X. The diagnosis was X pain. X was recommended and X was prescribed.

On X, Dr. X ordered X evaluation and treatment for the X.

On X, the patient was seen at X for an initial X evaluation for the X. The patient continued to report X. X had X due to X. X tests were X. Examination showed X. X was planned X.

On X, a preauthorization request by X, X, was documented. In all, X sessions were ordered.

Per Utilization Review dated X, completed by X, M.D., the request for X as requested by Dr. X was denied on the basis of the following rationale: "*Official Disability Guidelines recommends X. The documentation provided detailed that an MRI of the X. It was detailed that the patient had completed X sessions and that X sessions have been approved on X. The progress note dated X, detailed that the patient had X. X examination detailed a X test with a X. The patient was recommended for X. However, this request exceeds the guideline recommendations and modification cannot be made without a peer to peer discussion and agreement. Additionally, there was no documentation provided that the patient would not be able to transition to a X. There are no exceptional factors to support extending treatment outside of guideline recommendations.*"

On X, the patient was seen by X, PA-C/Dr. X for the X pain and X. X continued to have X. The patient's pain X; hence Dr. X recommended X. Examination showed X. The X was X; X was X and X. The diagnoses were X. X and then X sessions with a X were recommended.

On X, X, M.D., completed a peer review. The compensable injury for the date X, extends to include a resolved X. The patient had X. The work event was a X. The current X pain was not directly related to the compensable work injury. The diagnostic imaging reported X. The ODG would not support the current or recommended treatment, including X and following with the treating physician. No further X would be supported. The current disability was not a direct result of the compensable injury.

On X, Dr. X ordered X.

Per Utilization Review dated X, completed by X, M.D., the request for X as requested by Dr. X was denied on the basis of the following rationale: *"The request was previously noncertified on X, due to lack of medical necessity. Additional documentation includes progress notes from X. The previous noncertification is supported. The request exceeds the Official Disability*

Guideline treatment recommendations. The patient has X. There is X on MRI. There is a lack of X supporting improvement with the X completed to date. The appeal request for X, is not certified."

On X, a Prospective Review Response was documented. *"X maintains its position that the proposed treatment for X as requested by Dr. X is not medically reasonable and necessary for the treatment of the compensable injury. The compensable area is listed as X. The carrier has not disputed other diagnoses. Significant past medical history is X. According to documentation, X was diagnosed with a X. Treatment included X. As noted by the Physician Advisors during the Adverse and Appeal Denials, MRI of the X. The current pain level was X. It was also reported that X X had been approved on X. X notes were not submitted for review. According to the Treatment Guidelines, the duration of treatment at any one level of care may be less than or greater than the recommended duration depending upon the documented condition of the injured worker. As also mentioned above by the Physician Advisor during the Adverse and Appeal Denials and Rationale, although the patient was noted to be X. The Official Disability Guidelines allow up to X. In this case, the patient had already completed X. As also stated by the Physician Advisor, the request exceeds the guidelines recommendations and there was no documentation provided that the patient would not be able to transition to a X. Unfortunately, Dr. X was not available for peer to peer discussions during the Adverse and Appeal Determination Denials. Therefore, based on the reviewed documentation, the medical necessity for the proposed X as requested by Dr. X in a patient where there was X."*

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

After review of the medical records it appears the diagnoses include X. ODG clearly recommends X for the diagnoses above and there is no documentation why one should exceed the Guidelines. MRI revealed. It is my opinion additional therapy is not warranted or medically necessary.

X Not 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