IMedReviews
14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

DATE OF REVIEW: 12/10/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX injection, Fluoroscopic guidance" for the patient.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

D.O. Board Certified in Anesthesiology and Pain Management.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XXXX who was injured on XXXX and is presently complaining of XX XX pain and XX leg XX. Patient underwent an MRI on XXXX with the impression of XX XX changes with XX XX XX from XX-XX to XX-XX and XX XX and XX XX exiting XX and XX exiting XX nerve roots. A CT scan of the XX XX with contrast performed on XXXX showed XX XX disc XX with XX of the XX spaces and XX body XX XX present. XX changes were present involving XX joints at XX, XX-XX and XX-XX levels. Patient also underwent XX of XX XX with CAT scan to follow as pre-operative diagnostic test on XXXX. XXXX had an XX and XX XX epidural steroid injection on XXXX with limited success. Post procedure follow up XXXX patient continues to complain of XX pain score XX/10 and described the pain as XX, XX in nature and XX in quality. On physical exam patient had a positive XX and XX XX and XX and ankle tendon XX were absent on the XX. Sensation to light touch on XX XX XX was XX. Patient was taking XXXX.

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

Per ODG references, the requested "XX XX injection, Fluoroscopic guidance" is not medically necessary. According to ODG, there should be at least XX positive exams to suggest the diagnosis which was not met in this case.

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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 KNOWLEDGE BASE
- ☐ AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES