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DATE OF REVIEW: 12/27/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Authorization and coverage for XXXX XX joint injection under fluoroscopy under sedation XX, XX, XX, XX, XX, XX.

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

M.D., Board Certified in Anesthesiology, 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)

I have determined that part of the requested is medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. XXXX MRI shows mild XX joint XX and a XX collection, which represents XX. XXXX is taking XXXX and has tried Physical therapy. The request is for a XX injection under fluoroscopy and with sedation.

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

ODG criteria allows for XX injections in this case. This is XXXX FIRST injection. This is NOT a repeat injection or a series of injections. ODG criteria do not support the use of fluoroscopy or ultrasound; however, the peer reviewed literature has established image guidance as the standard

of care. (Bloom JE et al. Image guidance versus blind glucocorticoid injection of the XX. Cochrane Database System Rev 2013. XX).

Sedation would be indicated only XX. There is NO documentation of any indication for sedation.

Therefore**,** I have determined the requested injection is medically necessary for treatment of the patient's medical condition, but the fluoroscopy and sedation are not.

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**
- ☐ **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)**

  Bloom et al. Image guided versus blind glucocorticoid injection of the shoulder. Cochrane Database System Rev 2012 CD009147

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