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Date notice sent to all parties: 12/03/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX

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

Board Certified in Anesthesiology
Fellowship Trained in Pain Management
Certificate of Added Qualifications in Pain Medicine

REVIEW OUTCOME:

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

X Upheld (Agree)

☐ Overturned (Disagree)

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

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

XX – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was allegedly injured on XXXX. XXXX was initially treated by XXXX for complaints of XX XX XX and XX pain. On XXXX, a XX MRI scan was performed to evaluate this XX XX XX and XX pain, demonstrating XX XX and disc XX at XX-XX and XX-XX with moderately severe XX and mild XX XX-XX foraminal XX, as well as a XX XX-XX disc XX severely XX the XX XX XX and compressing the XX XX XX root. These findings clearly did

not correlate with the patient's complaint of XX XX and XX pain. XXXX continued treatment with XXXX and was referred to XXXX who noted the discrepancy between the MRI findings and the patient's pain complaints, but nevertheless performed XX XX-XX and XX-XX transforaminal ESIs on XXXX. Subsequent follow-up indicated that the patient continued to have XX XX pain, despite alleged relief of XX pain. XXXX continued treatment with XXXX with no change in symptoms through XXXX when XX XX through XX XX XX blocks were performed, providing no more than a XX of relief. A second set of XX XX blocks was requested but denied. On XXXX, the patient began XX treatment with XXXX, lasting through XXXX.

On XXXX, acting as a Designated Doctor, determined that the extent of injury did not extend to or include the preexisting XX through XX XX disc disease, XX-XX and XX-XX foraminal XX, and XX XX. On XXXX referred the patient to XXXX for surgical evaluation, who initially recommended XX-XX XX surgery. The patient returned to XXXX for ongoing treatment through XXXX, who reported no significant change in XXXX XX XX and now XX or XX XX complaints. On XXXX performed right XX-XX XX with XX XX-XX and XX-XX medial XX and nerve root XX with XX decompression. Despite surgery, the patient continued to complain of the same XX XX pain postoperatively. On XXXX, the patient was evaluated by XXXX at the request of XXXX for XXXX ongoing complaint of XX XX pain. XXXX reviewed the patient's history to date and the failure of relief after multiple injections and XX surgery. A XX MRI scan was reviewed by XXXX, allegedly ordered by XXXX, demonstrating recurrent XX XX-XX disc XX impinging on the XX XX nerve root. XXXX recommended XX XX-XX and XX XX transforaminal ESIs. The patient followed up with XXXX, now complaining of XX XX pain with XX radiating down XX XX. XXXX reviewed a XX MRI study from XXXX demonstrating XX XX on the XX at XX-XX with a recurrent disc XX resulting in XX recess XX and right XX XX, as well as mild XX-XX and XX-XX XX disc disease. XXXX now recommended XX XX-XX XX joint injections. Two separate physician advisors reviewed that request, once by XXXX followed by XXXX both of whom recommended non-authorization based on both the Official Disability Guidelines (ODG) and the exclusion of facet disease as part of the compensable injury.

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

As discussed above, this patient has already undergone XX XX blocks of the XX-XX level initially with the medical records reporting no more than an XX of relief from that procedure. Additionally, XXXX has undergone surgery including XX-XX XX. XXXX current pain complaints are not only of XX pain, but also of pain/XX radiating down XX XX. Since the patient no longer has an XX-XX XX joint, based on the surgical XX that XXXX performed, and has XX symptoms into XXXX XX, XXXX is clearly not a candidate for XX XX injections, since a non-existent XX joint cannot be injected. Additionally, since XX branch blocks previously provided no relief, this indicates that the XX joint is not the pain mediator. Therefore, the requested XX XX joint injection XX at XX-XX is not reasonable, medically necessary, or in accordance with the ODG and therefore, the previous adverse determinations are hereby 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**

☐ **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**

X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **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 (PROVIDE A DESCRIPTION)**