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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX XX block XX, XX XX on the XXXX

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

Pain Medicine, Physical Medicine & Rehab

REVIEW OUTCOME:

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

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

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. XXXX developed XX pain, XX XX pain, XXXX XX and XX pain, and XX XX pain. The diagnosis was XX of the XX region and strain of XX, XX and XX at the XX level, initial encounter. On XXXX for the complaints of XX XX pain that radiated into the XXXX XX XX. The physical examination remained unchanged from the prior visit. A XX epidural steroid injection was performed at the XX level. On XXXX status post XX epidural steroid injection. XXXX reported improvement in pain greater than XX% in the XXXX XX XX; however, the XX XX on the XXXX side had not improved. XXXX XX and XXXX XX were hurting constantly. XXXX also experienced tingling in XXXX XX. XXXX noted to have soreness in the XX of the XXXX XX. A CT scan of the XX XX dated XXXX revealed XX XX disease and XX XX XX throughout the XX XX. There was mild neural XX XX at the XX-XX level. X-rays of the XX XX were performed XXXX, reporting XX narrowing at XX discs except XX, advanced at XX and XX with XX off the XX joints and moderate XX of the mid XX XX joints XX. An MRI of the XX XX dated XXXX showed XX XX XX at the XX and XX levels. The XX XX was XX mm in maximum AP dimension due primarily to XX mm XX disc XX. The XX XX fluid space

was partially XX. There was compromise of the XX XX that could result in XX symptoms. There was borderline XX XX XX at the XX and XX levels. The XX XX was XX cm due primarily to XX mm XX / XX. There was neural XX compromise that could result in XX symptoms. Treatment to date included a XX XX, medications (XXXX) XX therapy (completed XX sessions) and activity restrictions.

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 XX XX blocks at XX and XX, XX branch on the XXXX. XX: Injection XX XX joint XX / XX XX level, XX: Injection XX XX joint XX / XX XX level, XX: Injection XX XX joint XX / XX XX level, XX: XX for XX injection, XX: Anesthesia, XX block / injection, XX, XX: Injection, XXXX, not otherwise specified, XXXX, XX: Injection, XXXX is not recommended as medically necessary and the previous denials are upheld. Per the adverse determination letter dated XXXX, the request for XXXX XX XX block at the XX and XX levels was denied. It was determined that at the time, for the described medical situation, Official Disability Guidelines would not support a medical necessity for the specific request. The reference would not support a medical necessity for the specific request, as there was documentation of symptoms consistent with a XX XX. With such documentation, presently, medical necessity for the specific request as submitted was not established per criteria set forth by the above-noted reference. Per the utilization review adverse determination letter dated XXXX, the reconsideration request for XX XX blocks at XX and XX, XX branch on the XXXX, was non-authorized. The request was previously non-certified by XXXX, as the guidelines did not support the requested procedure. No additional documentation was provided to support the request. The previous non-certification was supported. According to the guidelines, the use of diagnostic XX injections was only recommended to be used prior to a XX XX, which was a procedure that was not recommended by the treatment guidelines. Also, the guidelines stated there should be at least XX weeks of failed conservative treatment to include XX therapy, home exercise program, and NSAIDs. There was no mentioning of or documentation to support that the claimant had completed at least XX weeks of active participation in XX therapy to support the request. The request for XX XX block XX and XX XX branch on the XXXX was not certified. There is insufficient information to support a change in determination, and the previous non-certification is upheld. First, the CPT codes do not match the request as XX and XX XX blocks are a XX-XX procedure; however, code XX is for a XX level. CT of the XX XX notes that the XX joints and spinous processes are normal in alignment. MRI of the XX XX notes that at XX there is loss of disc signal otherwise this level is normal. Peer review dated XXXX indicates that the compensable injury would extend to include a XX and XX strain and XX wall XX. The original injuries are reported to have resolved.
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

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL