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DATE NOTICE SENT TO ALL PARTIES: 12/19/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a XX XX XX XX XX under fluoroscopy with IV XX.

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

The reviewer is a Medical Doctor who is board certified in Anesthesia and Pain Management. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a trial dual XX XX XX under fluoroscopy with IV sedation.

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. XXXX was seen for follow-up on XXXX, underwent appropriate XX evaluation ruling out to major XX or XX XX for persistent XXXX XX, XX and XX pain associated with persistent XX pain following XX injury. Patient rates pain XX or XX out of 10, has marked XX, XX throughout XXXX XX, XX and XX, feels XXXX is often XX things. The provider indicated that during the trial period, we will look to eliminate the XXXX which is up to XXXX XX times per day, may continue XXXX.

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

XX

Based on the records submitted and evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per ODG, XX XX XX (XX) are recommended only for selected patients with specific conditions and in cases when less invasive procedures have failed or are contraindicated. The patient was recommended a XX of XX XX XX. However, there was limited documentation of pertinent objective findings to fully meet the criteria and justify the need for the request. In addition, there was no documentation that XX XX XX (XX) would be used in conjunction with other comprehensive multidisciplinary medical management. Therefore, it is not medically necessary at this time.

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)**

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