True Decisions Inc.

An Independent Review Organization
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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:
Pain Medicine and XX Medicine

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 who was diagnosed with XX and XX strain. XXXX sustained an injury on XXXX. XXXX. XXXX for an evaluation of XXXX. XXXX reported having XX pain since XXXX. Treatment had included heat, which relieved the pain and XX therapy which helped the pain. The pain was located XX. The pain was XX and was rated XX/10. XXXX range of motion was stiff. XXXX stated that symptoms were increased with activity, sitting, standing, getting up from a chair, bending forward and backwards, walking, twisting, climbing stairs, and changing positions. The symptoms were better with lying down. Other symptoms included XX. On examination, XXXX gait was favoring the XX. XX test was positive on the XX. An XX of the XX performed on XXXX showed XX XX measuring XX mm seen at XX, which in addition to thickening of XX and XX joints was creating XX and XX, XX greater than XX, and mild XX secondary to XX XX measuring XX mm with XX joint. Treatment to date included medications (XXXX) and XX sessions of XX therapy with improvement. Per a Notification of Adverse Determination dated XXXX, the requested service of XX injection was non-certified. The primary reasons for the determination were: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, XX is recommended as a possible option for short-term treatment of XX pain with use in conjunction with active rehab efforts. The XX of the XX dated XXXX showed XX and XX XX measuring XX, which in addition to thickening of XX and XX joints was creating mild central XX, XX greater than XX. Per XXXX report, XXXX complained of XX

pain associated with positive XX. However, recent clinical finding had insufficient documentation of other focal evidence of XX specific to the XX level. The records submitted were also limited to objectively validate the exhaustion of all appropriate conservative treatments, as well as the patient's response from the treatment provided, prior to the consideration of the request. An exceptional factor was not clearly identified." Per Notification of Reconsideration Adverse Determination dated XXXX, the requested service of XX injection was non-certified. The primary reasons for determination were: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. XX root XX was XX and in the recent medicals there were no XX deficits, the sensation was intact with normal reflexes, coordination, muscle strength, and tone. The objective findings presented were limited to fully established XX XX at the specific XX level. The records submitted were also limited to objectively validate the exhaustion of all appropriate conservative treatments, as well as the patient's response from the treatment provided, prior to the consideration of the request."

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 at XX is not recommended as medically necessary. Per a Notification of Adverse Determination dated XXXX, the requested service of XX was non-certified. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines require documentation of XX on physical examination corroborated by imaging studies and/or XX results. The patient's physical examination fails to establish the presence of active XX. There is no documentation of a sensory or motor deficit in a XX or XX. There is no XX documented on XX XX. Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the decision is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES