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An Independent Review Organization
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Date: 11/20/2018 and Amended 11/20/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 1 XX XX block

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Pain 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. XXXX was diagnosed with other XX XX, XX, XX XX pain, XX, XX, XX, and XX. XXXX for XX XX pain. XXXX stated that the frequency of pain was XX, and the quality of pain was XX. The aggravating factors included movement, turning to the XX, increased activity, and lifting. XXXX had tried manipulation, medications, rest, injections, and heat in the past to alleviate XXXX pain. The pain was rated at XX/XX. XXXX posture of XX was XX. XXXX woke up XX times during the XX due to pain. On examination, XXXX had pain when the XX was XX. The strength of the XX extremity XX was XX/5. XXXX was status post XX XX XX block, which provided XX% pain relief for XX days and XX% ongoing relief. XXXX had an increase in temperature from pain relief. XXXX desired to proceed with the upcoming block. On XXXX, XXXX stated that the pain in XXXX XX XX XX had increased and range of motion had decreased since XXXX insurance continued to deny XX therapy and injections. The pain was rated at XX/XX. XXXX pain was relieved by 0% by XXXX ongoing drug regimen. XXXX was XX at the time. The treatment to date included medications (XXXX), XX therapy, and XX XX XX block (XXXX). Per a utilization review decision letter dated XXXX, the request for one XX XX block between XXXX was denied. Rationale: "In my judgment, the clinical information provided does not establish the medical necessity of this request. Understanding the date of injury, noting the injury and the current clinical situation as well as the efficacy of the prior (XX% ongoing pain relief) and incorporating specific parameters identified in the Official Disability Guidelines it is not clear that there was sufficient reduction pain medication or an increase in tolerance of activity. Therefore, based on the information presented for review this is not

clinically indicated at this time. As such, the request for 1 XX XX Block - (XX Codes: XX Injection for XX block.) is not medically necessary." Per a reconsideration review decision letter dated XXXX, the appeal for one XX XX block between XXXX was not approved. Rationale: "In my judgment, the clinical information provided does not establish the medical necessity of this request. This is an appeal to review XXXX, which was non-certified by XXXX. Based upon the available documentation and noted guidelines, this reviewer does not recommend approval for the requested services as reasonable or medically necessary. The request is not associated with noted guidelines criteria, which indicate a successful block fulfills criteria for success including that XX temperature after the block shows sustained increase (= XX.XX° C and/or an increase in temperature to XX) without evidence of XX or XX sensory block. Documentation of motor and/or sensory XX should occur. A XX sign should be documented for XX XX blocks. A successful XX block would be noted by XX syndrome. This reviewer does not appreciate these findings in relation to the previous XX XX block. As such, the request for 1 XX XX Block - (XX Codes: XX Injection for nerve block) is not medically necessary."

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 One XX XX block between XXXX is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review decision letter dated XXXX, the request for one XX XX block between XXXX was denied. Rationale: "In my judgment, the clinical information provided does not establish the medical necessity of this request. Understanding the date of injury, noting the injury and the current clinical situation as well as the efficacy of the prior (XX% ongoing pain relief) and incorporating specific parameters identified in the Official Disability Guidelines it is not clear that there was sufficient XX pain XX or an increase in tolerance of activity. Therefore, based on the information presented for review this is not clinically indicated at this time. As such, the request for 1 XX XX Block - (XX Codes: XX Injection for XX block.) is not medically necessary." Per a reconsideration review decision letter dated XXXX, the appeal for one XX XX block between XXXX was not approved. Rationale: "In my judgment, the clinical information provided does not establish the medical necessity of this request. This is an appeal to review XXXX, which was non-certified by XXXX. Based upon the available documentation and noted guidelines, this reviewer does not recommend approval for the requested services as reasonable or medically necessary. The request is not associated with noted guidelines criteria, which indicate a successful block fulfills criteria for success including that XX temperature after the block shows sustained increase (= XX and/or an increase in temperature to XX) without evidence of XX. Documentation of XX should occur. XX. A successful XX block would be noted by XX. This reviewer does not appreciate these findings in relation to the previous XX XX block. As such, the request for 1 XX XX Block - (XX Codes: XX Injection for XX block) is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certification is upheld. Office visit note dated XXXX indicates that XXXX had a block on XXXX which helped to decrease XXXX pain for XX hours, but XXXX states that now XXXX pain is worse and XXXX feels like it did on the day XXXX was XX. Follow up note dated XXXX indicates that the patient reported XX pain relief for XX days and XX ongoing following XX XX XX block. There are no objective measures of improvement following prior XX XX block.

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:

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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES