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DATE NOTICE SENT TO ALL PARTIES: 11/13/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of XX XX injections at 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 Physical Medicine and Rehabilitation. 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 XX branch XX.

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. The mechanism of injury is not reported. XXXX has a history of prior XX at XX. XXXX complained of XX pain. An XX was performed XXXX showing preservation of XX height with XX XX, no bulging, XX or XX. XX shows no XX or XX.

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

The reviewer's decision for non-authorization of this procedure is based upon current accepted standards of practice and the ODG guidelines for management of XX pain. Conservative care has not been exhausted. The patient continues to XXXX and is not participating in a home exercise program. There is not sufficient evidence to overturn this denial. The treatment provided has not been documented as to the effectiveness.

ODG Criteria for the use of diagnostic XX XX pain:

XX

ODG pain chapter does not recommend XX XX for XX pain. If XX XX are considered for XX pain, the pain needs to be non-XX and at no more than two levels XX. There must be documentation of failure of conservative treatment including home exercise, PT and XX prior to the procedure for at least XX weeks. If performed they are done with anticipation that if successful treatment may proceed to XX XX at diagnosed levels. Again, they are not recommended for XX pain. Therefore, based upon the entirety of these reasons, the requested procedure is not medically necessary.

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)**