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DATE OF REVIEW: 9/19/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

"1 XX XX injection under ultrasound guidance XXXX for the patient.

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

M.D. Board Certified in Orthopedic Surgery and Sports Medicine.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is an XXXX with a date of injury stated as XXXX. There are no details of the injury in the available notes. Per the office note only the XX XX is listed as a XX injury. As of the last office note on XXXX the patient complained of XX, XX, and XX pain in XX XX. On exam XXXX was found to have a XX XX XX test, XX XX XX test, and XX rotator cuff XX. An MRI was done of only the XX shoulder on XXXX that showed a XX XX XX XX XX with XX changes in the XX joint. XXXX is currently using XXXX for pain. There is no documentation of any other prior treatments.

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

Per ODG references the requested "XX XX shoulder injection under ultrasound guidance XXXX" for the patient" is not medically necessary.

Per the MRI, the patient has XX XX XX in the XX XX. If XXXX has not had prior steroid injection or has had a good response to this in the past for XX months or longer then doing a steroid injection for the XX XX might be reasonable in this case with an XX patient where

surgery to address this might not be desired or a possibility. There is no documentation if XXXX has had an injection in the past. If there is objective evidence of the same diagnosis on the XX side, then an injection would be reasonable as well. Again, there is no documentation of any imaging of the XX XX and the XX XX may not be compensable anyway based on the note. Either way the current request would be denied because use of ultrasound guidance for the shoulder injections is not indicated. While there may be some evidence that ultrasound guidance may improve the accuracy of needle placement there is no good evidence that this has any effect on the clinical outcome of the injection. For this reason, the current request 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 KNOWLEDGE BASE
- ☐ 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