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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:

Board Certified in Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]: Patient is a XXXX who presents with a history of an XX claim from XXXX. The mechanism of injury is detailed as a XXXX. The current diagnosis is documented as XX XX of the XX XX. Past treatment includes: medications, PT, and chiropractic therapy. The XXXX is denying the request for XX.

XXXX – Physician Notes- **XXXX**: Subjective: Generalized pain. HPI: Knee/Shin: **XXXX** presents with c/o pain XX XX knee pain and some knee and shin pain. Pt denies any trauma or bruising. Pt has not changed activities. Pain started in **XXXX**. Onset: sudden; Severity: 5-9/10; Nature: aching and some burning; Aggravated by: none; Relieved by: position change. Pain on **XXXX** started on XX knee. **XXXX** does not help. Medical history: XX XX. Surgical history: XX in XX in **XXXX** and XX XX in **XXXX**. Examination: Knee/Shin: Knee: XX. Inspection: XX XX XX XX with xx xx, no xx; Palpation: No tenderness on XX or XX XX. ROM: Normal flexion and extension. Motor flaccid with xx. Gait in w/c

and independent propulsion. Sensory decrease to light touch over xx. Assessment: Knee pain – XX.XX (Primary), secondary to central pain vs XX. No local swelling. Pt has some XX around the XX knee secondary to leg XX. Plan: Knee pain – Increase **XXXX**. Diagnostic Imaging: X-ray; Knee, XX. Follow up: Maintain f/u with **XXXX**.

XXXX – Radiology Results- **XXXX**: Reason for exam: XX XX pain. XX knee: Two views of XX knee obtained. No fracture or osseous abnormality is seen. Joint space is maintained. Impression: Unremarkable XX knee.

XXXX – MRI Results- **XXXX**: Exam: MRI XX XX w/o contrast. Indication: XX; XX XX; incomplete XX of the XX XX; history of XX XX injury **XXXX**. Findings: Technically limited study. Post-surgical changes status post-XX are demonstrated at XX-XX with XX plate and screws. Multilevel XX XX is seen with XX XX XX at XX-XX. Abnormal increased XX/decreased XX signal is seen within the XX XX XX extending from XX-XX through XX with associated XX XX. Decreased signal within the XX XX epidural space at XX-XX is likely XX. No significant abnormalities are demonstrated at the XX junction. No significant XX soft tissue signal XX are seen. Impression: 1) Technically limited study. Follow up on a XX.XX or greater magnet may be beneficial. 2)Postsurgical changes status post XX at XX-XX. XX) Abnormal XX XX and XX at XX-XX likely related to XX XX to the patient's injury. 4) Decreased XX XX in the XX XX space at XX-XX likely XX. X) Mild XX XX XX at XX-XX.

XXXX – Physical Medicine Evaluation- **XXXX**: History: This is a follow up visit for **XXXX** who was last previously seen by XX in **XXXX**. XXXX comes in today with complaints of pain in the XX XX XX area. XXXX indicates that the pain seems to be related to XXXX XX program. XXXX does not do anything that brings the pain on, other than the days that XXXX has XXXX XX XX, which consists of XX and XX. Physical Examination: XXXX was placed supine on the exam table. Abdomen was XX, XX-XX. Musculoskeletal testing did not reveal any provocative signs. The abnormal sensation appeared to be in the XX of the XX XX XX nerve or the XX nerve on the XX. Assessment: Suspect the pain may be referred pain to the distribution of the XX XX XX or XX nerve from either an internal organ such as XX or XX XX XX vs XXXX organs, or perhaps XX pain from a XX that has subsequently developed at a later time in the XX XX. Plan and Recommendations: I would recommend XXXX see a GI doctor, as the symptoms are seemingly related to the XX XX. If needed, the GI doctor may want to get a CT scan of the XX. If GI work-up is negative for source of pain, would recommend an MRI of the XX XX to rule out XX of the XX XX.

XXXX – Physical Medicine Follow up Visit- **XXXX**: History: This is a follow-up visit for XXXX who was last previously seen by XX in **XXXX**. XXXX comes in still with XXXX major

complaint being the XX XX XX XX pain with some referred pain into the XX XX area and XX area. XXXX indicates XXXX has had some XX XX by **XXXX** that did help XXXX symptoms a little bit but not completely. XXXX indicates that the symptoms are worse on the days that XXXX does not have a XX XX XX. XXXX has an appointment with **XXXX**. XXXX also feels like XXXX XX XX muscle is getting weaker. Current Medications: **XXXX**. Assessment: XX pain and referred pain into the XX, unclear etiology. The symptoms could be coming from a XX XX pain versus a XX in the XX XX at the site of the original injury. Plan and Recommendations: 1) No change in current medications. 2) Recommend XXXX pursue consultation with **XXXX** regarding the etiology of XXXX chronic XX XX XX pain that is associated with XXXX XX XX. 3) Will again request MRI scan of the XX XX. Will also include the XX XX. I did request and MRI scan back in **XXXX**; however, the patient does not recall obtaining this MRI. 4) I did recommend that XXXX talk to XXXX anesthesia pain management physician and if the XX blocks do not help significantly, perhaps XXXX would be a candidate for a XX XX block.

XXXX – MRI Results- **XXXX**: The patient denies prior history of surgical XX/XX of a portion of the XX and XX. Revised Impression is as follows: Impression: 1) Interval thinning and attenuation of the XX XX and XX (compared to MR study dated **XXXX**). This is likely secondary to pressure XX/XX XX secondary to XX/XX. 2) No acute fracture, XX XX lesion, or XX. Exam: MRI XX and XX w/o contrast. Reason for exam/History: XX pain, XX.XX XX pain XX. Comparison: MR XX **XXXX**. Findings: Bone and Joint: Anatomic alignment is maintained at all articulations about the XX. No acute XX XX fracture, XX XX fracture, XX dislocation, or XX XX lesion. The XX joints are normal. The XX is shortened and there has been interval removal of the XX XX and XX compared to previous MR study dated **XXXX**. The XX terminates at the XX. There is no soft tissue abnormally along the XX XX. Soft tissues: An XX XX XX is seen in the XX XX XX. The XX and XX are unremarkable. The visualized XX and XX XX are unremarkable. There is no free fluid in the XX. No XX or XX XX. The XX XX roots are normal in course and caliber. Impression: 1) Interval XX/XX of the XX XX and XX. The remaining XX shows normal morphology and MR signal. 2) No acute fracture, XX XX lesion, or XX.

XXXX – MRI Results- **XXXX**: Exam: MRI XX XX w/o contrast. Indication: XX XX similar: XX XX; XX. Comparison: MRI XX spine **XXXX**. Findings: Post-surgical changes status post XX are seen extending through XX. Mild chronic XX XX XX XX of the XX XX is seen. No acute fractures. Multilevel XX XX is noted. The XX XX XX is grossly normal in signal and morphology. No significant XX XX XX, XX XX XX or XX compromises. There is XX XX in the lower XX XX. No significant XX or XX soft tissue signal abnormalities. Small XX XX XX are incidentally noted, left greater than right. Impression: 1) Chronic XX XX of the XX XX. 2) XX XX XX. 3) No significant XX XX XX or XX. 4) Small XX XX XX.

XXXX – Physical Medicine Follow up Visit- **XXXX**: History: This is a follow-up visit for **XXXX** who was last previously seen by XX in **XXXX**. XXXX comes in complaining of some XX XX pain between the XX XX and XX on the XX. XXXX reports the pain is very sensitive and at a level of XX. XXXX describes a XX quality of pain. XXXX indicates that the **XXXX** injection in the XX helped. XXXX is currently taking **XXXX**. Physical Examination: XXXX was placed on the table. The skin over the XX and XX region was examined. There were no XX or XX; however, there was a XX quality to XX XX in this XX, XX XX XX levels. There was also some XX tightness noted in the XX XX and the XX XX. Assessment: 1) XX pain, XX XX-XX root level. This could be a combination of XX XX and deformity of the XX secondary to the XX. Plan and Recommendations: 1) I did discuss this case with **XXXX** who is in agreement that a XX XX-XX-XX root blocks may be beneficial. 2) Therefore, will refer to **XXXX** for a left XX-XX XX root block.

XXXX – Peer Review- **XXXX**: Per the initial request a medical opinion review regarding medical services for **XXXX** has been completed. The following summary outlines the recommendation of the reviewing advisor. Review Determination Recommendation: Non-Certified. Issues to be analyzed: Request: Is the request for XX XX and XX XX XX XX Injection XX medically necessary? Date of Injury: **XXXX**. Diagnosis: XX.XX (XX) XX XX of the XX XX, with other complications. Medical Records Reviewed: 10 pages of medical and administrative records were reviewed including: **XXXX** -medical notes- **XXXX** -MRI XX and XX- **XXXX** -medical notes- **XXXX** -medical notes- **XXXX**. Request: Is the request for the XX XX and XX XX XX XX Injection XX medically necessary? Determination: The request is not certified. Principal Reason(s) for Determination: 1) Lack of appropriate imaging findings; 2) Lack of appropriate physical examination findings; 3) Lack of exhaustion of lower levels of care. Reviewer's Comments: The claimant is a XXXX who was injured on **XXXX** in a XX that was not XX. The claimant was diagnosed with XX pain. An MRI of the XX and XX without contrast was performed on **XXXX**, which revealed the following: XX XX/XX of the XX XX and XX with the remaining XX showing normal morphology and MR signal, no acute fracture, XX XX XX, or XX. An evaluation on **XXXX**, revealed that the claimant was having XX XX pain. Current medications included **XXXX**. The physical examination revealed XX quality to light touch over the XX XX and XX in a left XX XX level and there was some XX tightness noted in the XX XX and right XX. The claimant has continued pain in the lower back. According to the guidelines, an XX XX injection is recommended to treat symptoms of XX pain that is confirmed on a clinical exam findings and diagnostic imaging. There is no evidence of nerve root XX on diagnostic imaging and there were no clinical exam findings to include weakness, loss of reporting sensation, or positive XX XX raise noted to support the request. The guidelines also state there should be failure of previous conservative treatment to include physical therapy, anti-inflammatories, muscle relaxers, and neuropathic medications. There was no documentation provided to support failure previous conservative treatment of

physical therapy and anti-inflammatories. The request for XX XX and XX XX XX XX injection is not certified. Determination: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, this request is not certified due to lack of appropriate imaging findings, lack of appropriate physical examination findings, and lack of exhaustion of lower levels of care.

XXXX – Peer Review- **XXXX**: Per the initial request a medical opinion review regarding medical services for **XXXX** has been completed. The following summary outlines the recommendation of the reviewing advisor. Review Determination Recommendation: Non-Certified. Date of Injury: **XXXX**. Diagnosis: XX.XX (XX) XX XX of XX XX, with other complications. Medical Records Reviewed: 26 pages of medical and administrative records were reviewed including: **XXXX** -Prior Review- **XXXX** -Clinical Note- **XXXX** -MRI XX and XX-XX **XXXX** -Clinical Note- **XXXX** -Clinical Note- **XXXX**. Request: Is the appeal request for XX XX XX @ XX and XX medically necessary? Determination: Non-certified. Principal Reason(s) for Determination: There was no documentation noting significant quantitative objective findings indicative of XX on physical examination or imaging. Reviewer's Comments: The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. This case involves a now **XXXX** with a history of an XX claim from **XXXX**. The mechanism of injury is detailed as a **XXXX**. The current diagnosis is documented as XX XX of the XX XX. Past treatment included medications, chiropractic therapy and physical therapy. An MRI of the XX was performed on **XXXX** and showed no abnormalities. On **XXXX**, it was documented this patient had complaints of pain to the XX XX that XXXX rated 10/10. Upon physical examination, it was noted XXXX had a XX quality to light touch in the XX XX XX. According to ODG, XX XX injections are to reduce pain and inflammation thereby facilitating progress in an active therapy. They are to be given on the basis of radiculopathy that corroborates with imaging after the failure of conservative care. The request was previously denied as there was no documentation noting the failure of conservative care and there was no information noting XX on physical examination and imaging. The clinical documentation submitted for review indicated this patient XX physical therapy, chiropractic therapy, and medications. However, there was no documentation noting significant quantitative objective findings indicative of XX on physical examination or imaging. Consequently, the request is not supported. As such, the requested XX XX XX @ XX and XX remains non-certified.

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

The request for XX XX XX XX injection (XX) at XX-XX has been found to be not medically necessary and is denied. I am upholding the previous decision to refuse coverage for

this procedure.

This patient was involved in a XXXX. XXXX currently complains of pain in the XX XX, with referral into the XX XX area and XX region. XXXX has had improvement with XX XX in the past. The XXXX MRI of the sacrum identified removal of part of the sacrum and XX. The remaining XX was unremarkable. A recent examination identified XX to light touch in the XX XX XX. The treating physician recommended XX XX-XX-XX root blocks.

The Official Disability Guidelines (ODG) supports XX XX injections in patients with XX associated with a XX XX. The XX should be confirmed by imaging studies and/or electrodiagnostic testing.

This patient has no evidence of XX or XX XX. XXXX does not meet criteria for ESI. Therefore, the previous decision is upheld.

Per ODG:
ODG Criteria XX

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)**