Medical Assessments, Inc.

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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:

The Reviewer is Board Certified in the area of Anesthesiology with over 10 years of experience, including Pain Management

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]:

The claimant is a XXXX with a date of injury of XXXX. XXXX was injured while XXXX. XXXX diagnoses are XX XX pain and XX XX XX syndrome.

XXXX: Office visit by **XXXX**. Claimant underwent prior XX.

XXXX: Office visit by **XXXX**. Complained of XX XX pain. Current medications: **XXXX**. Pain was rated XX/XX with medications. On PE: pain is elicited by XX extension.

Straight leg raise is XX XX. Kepm's test is positive XX. Assessment notes XX post-XX syndrome, XX sprain, XX XX, chronic pain syndrome and XX XX pain.

XXXX: UR performed by **XXXX**. Rationale for denial: Claimant is a **XXXX** with date of injury **XXXX**. The claimant is diagnosed with XX XX pain and XX XX XX syndrome. Based on the information provided, the request for XX XX XX followed by XX XX XX is not recommended as medically necessary.

XXXX: Office visit by **XXXX**. Claimant presented for follow up visit. Claimant complained about XX XX pain. The claimant reported the pain relief from current medications reporting the pain was tolerable with current medications. XXXX reported home exercise program to manage symptoms, however, it was not working. XXXX reported XXXX was able to live at home but was not able to work.

XXXX: UR performed by **XXXX**. The claimant reported XXXX underwent a prior XX at the XX XX XX dated **XXXX**. The claimant reported that the derived XX% benefit over XX months in duration from the previous procedure. The appeal request for XX XX XX followed by XX XX XX one week after is non-certified.

XXXX: Office visit by **XXXX**. Claimant reported XX XX pain, XX XX XX pain. Reported pain with meds XX/XX, without XX/XX.

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

Based on the records submitted and peer-reviewed guidelines this request is non-certified. Claimant is a **XXXX** with date of injury **XXXX**. The claimant is diagnosed with XX XX pain and XX post XX syndrome. Claimant reported XX back pain, XX XX XX pain. Reported pain with meds XX/XX, without XX/XX. The claimant reported that the derived XX% benefit over XX months in duration from the previous procedure. Based on the information provided, the request for XX XX XX followed by XX XX XX is not recommended as medically necessary.

The request for XX XX XX followed by XX XX XX one week after is found to be not medically necessary.

ODG:

Criteria for use of XX XX XX XX:

(1) Treatment requires a diagnosis of XX XX pain using a XX branch block as described above. See XX XX XX XX (injections).

(2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at ≥ 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed over the course of a year.

(3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function.

(4) No more than two joint levels are to be performed at one time.

(5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.

(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.

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)**