# Medical Assessments, Inc.

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**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

XX diagnostic XX joint injection under fluoroscopy and monitored anesthesia

**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 who had an injury to the XX XX on XXXX.

**XXXX**: Follow up report by **XXXX**. Current diagnosis documented as XX; XX, not elsewhere. The claimant was evaluated for XX leg numbness and XX XX pain. XXXX rated this pain XX-XX/XX. XXXX reported that the symptoms had resolved since last evaluation. The claimant's numbness in the XX hip reported XX XX XX, XX XX thigh, XX thigh, XX calf and XX foot. PE revealed decreased sensation to pinprick in the XX XX

down the XX of the thigh/XX of the legs, into the leg/shins and into the XX of the feet. The claimant ambulated with an antalgic gait. Straight leg raise test was negative in the seated position bilaterally. Decreased XX was noted. Point tenderness was noted in XX XX-XX XX XX XX XX. ROM was limited in XX and XX. Claimant received relief from joint injection performed on XXXX. The claimant reported that medication and activity medication were no longer helping to control the pain.

XXXX: UR performed by XXXX. Rationale for denial: In this case, the patient has long-standing post XX syndrome, XX XX. It appears that recent XX XX did not improve XXXX pain substantially. XXXX had good relief for 2.5 months after recent XX injections. However, XX injection is not recommended according to ODG guidelines in the absence of rheumatologic disease. Therefore, the request for XX diagnostic XX joint injections under fluoroscopy and monitored anesthesia is not medically necessary.

XXXX: UR performed by XXXX. Rationale for denial: The patient reported that the most recent XX joint injection provided good relief. The patient complained of numbness in the XX XX that radiated down the XX XX XX. However, there was a lack of XX findings of pain related to XX joint pathology to support the request. Additionally, the patient had prior injection provided an objective decrease in pain and objective functional improvement to support a repeat injection. Therefore, the request for XX diagnostic XX joint injections under fluoroscopy and monitored anesthesia is not medically necessary.

**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. The patient reported that the most recent XX joint injection provided good relief. The patient complained of numbness in the XX hip that radiated down the XX XXX XX. However, there was a lack of physical examination findings of pain related to XX joint pathology to support the request. Additionally, the patient had prior injection provided an objective decrease in pain and objective functional improvement to support a repeat injection. Therefore, the request for XX diagnostic XX joint injections under fluoroscopy and monitored anesthesia is not medically necessary.

The request for Right diagnostic XX joint injection under fluoroscopy and monitored anesthesia is found to be not medically necessary

**ODG guidelines:**

**Not recommended, including XX XX-XX joint and XX complex diagnostic**

**injections/blocks (for example, in anticipation of XX XX). Diagnostic XX-XX injections are not recommended (a change as of August, 2015) as there is no further definitive treatment that can be recommended based on any diagnostic information potentially rendered (as XX therapeutic intra-articular injections are not recommended for non-inflammatory pathology). Consideration can be made if the injection is required for one of the generally recommended indications for sacroiliac fusion. See XX XX. Not recommended: XX XX XX nerve blocks and/ or XX XX blocks in anticipation of XX XX 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)**