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DATE OF REVIEW: 10/31/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
"XX XX XX between 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 a XXXX who sustained a work injury to XXXX XX on XXXX. Onset of symptoms began a XX later. XXXX has been diagnosed by XX on XXXX with a low-grade XX of the XX, with XX, XX XX without XX, mild XX, and XX. XXXX has been treated with XX, XX therapy, and has XX in the XX on XXXX. Per the notes for the XX XXXX responded for a few hours but then had return of symptoms. As of the last office note on XXXX continues to have pain in the XX that was XX to XX level which XXXX rated XX. XXXX was noted to have decreased range of motion and pain with resisted motion. XXXX had XX in the XX XX. XXXX had XX XX. The request at this point is for a repeat XX to the XX XX.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
Per ODG references the requested "XX XX between XXXX" for the patient is not medically necessary. The patient has had XX with limited improvement and the described response to the most recent XX of being better for only a few hours would suggest this may have been more from the XX in the XX than from the XX.

Repeat injections are not recommended if there is no response and generally not recommended without response for XX months. Also, repeat injections are not recommended to be done more than every XX months and not more than every XX months; another XX would be this patient's XX injection in a XX month period.

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