CASEREVIEW
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November 14, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX branch of the XX on XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician specializes in Physical Medicine and Rehabilitation and has over 18 years of experience.

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

☒ Overturned (Disagree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX. XXXX. Initial complaints included XX, XX and XX XX pain. Initial x-rays were normal. Initial diagnosis: XX and XX XX. XX was ordered. XXXX then began XX treatment with XXXX.

On XXXX, XX XX Impression: 1. Straightening of the XX, consistent with XX XX. 2. Disc XX XX XX XX and XX. XX. XX XX at XX mm. XX. XX disc XX of XX mm.

On XXXX, the claimant presented to XXXX reporting XXXX felt better following an adjustment. XXXX also completed an XX. Plan: Refer to XXXX to move forward with the consultation for an injection.

On XXXX, the claimant presented to XXXX with XX and XX pain described as intermittent to constant, XX, XX and XX. XXXX reported that sitting in one position, turning the XX, and physical XX the pain and symptoms. Pain relieved by rest, medications, and PT. On examination, ROM of the XX limited in all planes. XX over the XX processes was tender. Palpation over the XX was moderately XX at XX XX, and XX regions. Palpation over the XX revealed XX tenderness in the XX. Trigger points were noted with XX response and referred

pain noted. XX pain pattern was noted. XX was positive. XX XX test was positive. XX XX test was positive. XX sign was negative XX. XX Sign was negative XX. Right XX XX intermittent pain, XX, and XX. Plan: Prescribe XXXX. Recommend XX therapy. Consider epidural XX injection. Work restrictions.

On XXXX, the claimant presented to XXXX with chief complaint of XX pain with XX. XX was noted in the XX XX. XXXX reported XX was XX frequently by pain. On examination XX ROM was decreased. There was XX tenderness in the XX area noted on the XX at XX. Plan: XX XX branch of the XX XX XX on the XX and XX therapy.

On XXXX, the claimant presented to XXXX for XX XX XX Block XX on the XX.

On XXXX, the claimant presented to XXXX reporting improvement in overall pain by XX% after the XX. XXXX reported XX XX and decreased pain medication. Still working light duty. Plan: XX XX branch of the XX and XX on the XX.

On XXXX performed a UR. Rationale for Denial: At the present time, for the descried XX situation, Guidelines would not support a XX necessity for this specific request. This reference indicates that the requested procedure is considered to be under study. The submitted clinical documentation does not provide specifics as it relates to a XX XX XX. Additionally, the submitted clinical documentation does not provide specifics to indicate that past treatment in the form of a XX XX branch block significantly enhanced functional capabilities. Consequently, for the described XX situation, based upon the XX documentation available for review, the above-noted reference would not support a XX necessity for this specific request as submitted.

On XXXX performed a UR. Rationale for Denial: XX. In this case, the current request does not meet guidelines. The requested procedure is under study. The current exam does not outline XX XX joint pain at the requested levels. It is unclear if XX loading with XX extension elicits pain at XX. In addition, there is insufficient evidence of a plan of care with formal plan of rehabilitation. The XX necessity is not established.

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

Determination: denial of XX XX XX XX-XX and XX-XX XX branch XX XX on the XX is OVERTURNED/DISAGREED with since ODG recommendations and clinical criteria are met with documented successful diagnostic blocks at these levels with XX% reduction in pain, decreased use of medications, XX XX and continued work in a light duty capacity. The procedure is to be XX levels. There is documentation of previous conservative care with XX therapy prior to and plan after the blocks, with the anticipated longer duration relief afforded by this procedure to pursue end range rehabilitation. Therefore, I find the request for XX XX XX Levels XX branch of the XX XX on XX to be medically necessary.

PER ODG:

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 XX PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **XX JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED XX STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE XX DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR XX QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED XX LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**