Health Decisions, Inc.

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX Block XX/XX, XX/XX; XX Branch on the XX times one

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 repetitive XX motion at a XXXX which has resulted in XX XX pain and XX that occasionally radiates into the XX XX XX and has caused XXXX to be on restricted duty. Provider is requesting XX XX Block XX/XX, XX/XX; XX Branch on the XX times one.

XXXX – Physician Notes- **XXXX**: Reason for visit: Chief complaint: The patient presents today with injury happened on **XXXX** XX XX, XX, XX, and XX side of XX. Pain level XX/10. Self-reported. XX – Patient's occupation: XX. HPI: Vital signs were reviewed and found to be unremarkable. Length of time at job: **XXXX**; Average weekly work hours: XXXX. Acute XX injury history: Injured on **XXXX**. Occurred while at work. Complaint of XX pain. The pain is located in the XX XX XX. The symptoms occur intermittently. XXXX described XXXX pain as XX in nature. The severity of the pain is XX. Associated symptoms include XX XX and XX XX. Exacerbating factors include XX movement. Relieving factors include rest. Complaint of XX XX pain. XX XX and XX XX XX is affected. The symptoms occur intermittently. XXXX describes the pain as XX and XX in nature. The severity of the pain is XX. The pain radiates to the XX XX. Associated symptoms include decreased ROM. Exacerbating factors include XX motion. Relieving factors include rest. Assessment: XX) XX sprain (XX.XX). XX) Sprain of XX XX XX (XX.XX). Plan: **XXXX** XX) XX therapy referral for sprain of XX XX and XX XX, frequency XX x a week for XX weeks. 4) X-ray XX XX. XX) X-ray XX XX.

XXXX – X-Ray Results- XXXX: X-ray XX XX. Indication: XX pain. Findings: Straightening of normal XX XX noted. Normal XX alignment. XX show normal XX and architecture. XX XX changes seen at multiple levels. The XX bodies and XX elements are normal. The XX XX XX are reduced at XX-XX, XX-XX levels. An XX bone is seen at XX-XX level. No bony injury or lesion seen. Pre- and XX soft tissues are normal. Impression: Changes of XX XX with XX XX XX at XX-XX, XX-XX levels. X-Ray XX XX. Indication: Repetitive motion. Findings: Soft tissues are normal. Visualized bones show normal density, XX pattern and alignment. The XX surfaces of XX XX and XX show normal alignment. XX joint space is normal. No bony injury or lesion is seen. Impression: Normal XX.

XXXX – Physician Notes- **XXXX**: Reason for visit: Chief complaint: The pt presents XX with follow up. Self-reported. XX – Patient's occupation. HPI: Vital signs were reviewed and found to be unremarkable. XXXX is returning for a recheck of injury(s). Patient is doing better. XX Pain: The symptoms are improving. The pain is located in the XX XX XX. The symptoms occur intermittently. XXXX described XXXX pain as XX in nature. The severity of the pain is XX. The pain radiates to the XX XX. Associated symptoms include XX XX, XX XX. Exacerbating factors include XX movement and XX movement. Relieving factors include rest. XX Pain: Pain is located in the XX XX XX. The symptoms occur intermittently. XXXX describes XXXX pain as XX and XX in nature. The severity of the pain is XX. Pain radiates to the XX XX. Associated symptoms include decreased ROM and XX. Exacerbating factors include XX movement and XX rotation. Relieving factors include rest. Patient is taking meds as prescribed and XXXX is tolerating meds well. Patient has been referred to PT. Authorization is pending. Patient has been adhering to the work restrictions as prescribed. Assessment: XX) XX sprain (XX.XX). XX) Sprain of XX XX (XX.XX). XX) Sprain of XX XX XX (XX.XX). Plan: XX) XX Therapy referral; frequency: XX a week for XX weeks.

XXXX – Physician Notes- **XXXX**: Reason for visit: Chief complaint: The pt presents XX with follow up. Self-reported. XX – Patient's occupation. HPI: Vital signs were reviewed and found to be unremarkable. XXXX is returning for a recheck of injury(s). Patient is doing better. XX Pain: The symptoms occur intermittently. XXXX described XXXX pain as aching in nature. The severity of the pain is XX. The pain radiates to the XX XX. Associated symptoms include XX XX, XX XX and decreased XX ROM. Exacerbating factors include XX movement and XX use. Relieving factors include rest, XX anti-XX drugs, XX and XX XX. XX Pain: Pain is located in the XX XX XX. The symptoms occur intermittently. XXXX describes XXXX pain as XX and XX in nature. The severity of the pain is XX. Pain radiates to the XX XX. Associated symptoms include decreased ROM, XX and XX pain. Exacerbating factors include XX movement, XX rotation, XX elevation and lifting. Relieving factors include rest. Patient is taking meds as prescribed and XXXX is tolerating meds well. Patient has been adhering to the work restrictions as prescribed. Assessment: XX) XX sprain (XX.XX). XX) Sprain of XX XX (XX.XX). Plan: **XXXX.**

XXXX – Physician Notes- XXXX: Reason for visit: Chief complaint: The pt presents XX with recheck. Self-reported. XX – patient's occupation. HPI: Patient reports persistent pain on XXXX XX XX and XX. XX Pain: The pain is located in the XX XX XX and XX XX XX. The symptoms occur intermittently. XXXX described XXXX pain as XX in nature. The severity of the pain is XX. The pain radiates to the XX XX. Associated symptoms include XX XX, XX XX

and decreased XX ROM. Exacerbating factors include XX movement and XX movement. Relieving factors include XX, XX anti-XX drugs and PT. XX Pain: Pain is located in the XX XX XX, XX XX XX and XX XX XX. The symptoms occur intermittently. XXXX describes XXXX pain as XX in nature. The severity of the pain is XX. Pain radiates to the XX XX. Associated symptoms include decreased ROM and XX. Exacerbating factors include XX movement, XX rotation and lifting. Relieving factors include rest. Patient is taking the meds as prescribed and XXXX is tolerating medication well. Patient has been referred to PT and has attended therapy visits since the last visit. XXXX has been adhering to the work restrictions as prescribed. Assessment: XX) XX sprain (XX.XX). XX) Sprain of XX XX (XX.XX). Plan: XX) MRI XX XX without contrast. XX) MRI XX XX and contents, XX without contrast.

XXXX – MRI Results- XXXX: Exam: MRI of the XX XX without contrast. Clinical information: XX pain with XX XX extremity XX following a work-related injury on **XXXX**. Findings: Positioning/Alignment: The XX is normal. The XX XX are in XX position. There is no evidence of a XX. The XX XX bodies are in XX alignment. There is abnormal straightening of the normal XX XX XX. XX spaces/Vertebral bodies: The XX spaces and XX body heights are well-maintained. No fractures are visualized. Bone XX: There is no XX signal intensity in the XX XX. There are no XX or XX lesions. There are no areas of abnormal bone XX replacement. The XX sequence demonstrates no areas of abnormal bone XX XX. Impression: XX XX of the normal XX XX XX suggesting XX XX. At the XX/XX level, there is a XX XX XX (XX) measuring XX producing XX of the XX XX. Exam: MRI of the XX XX without contrast. Clinical information: XX pain with XX XX extremity XX. History of work-related injury on **XXXX**. Findings: There is a type XX XX in normal position. The XX joint shows mild XX changes with joint space XX, XX XX overgrowth and XX. There XX XX surrounding the XX. There is a small amount of fluid in the XX/XX XX and a small XX XX XX. The XX, XX, XX and XX tendons are intact with no partial or full thickness tears. The XX XX muscles are normal in XX with no XX, XX infiltration or XX XX. The XX tendon is located in the XX XX without XX. The XX XX complex is intact. The superior, XX and XX XX demonstrate normal XX with XX XX intensity. No XX tears are visualized. The XX, XX and XXX ligaments are XX. The XX XX is well maintained. There are no XX XX XX. The XX XX are unremarkable. Impression: XX) Mild XX changes of the XX joint surrounded by mild XX XX XX. XX) A small amount of XX in the XX which may be producing symptoms of XX. XX) A small XX XX XX. 4) No evidence of a XX XX or XX abnormality.

XXXX – Physician Notes- **XXXX**: Reason for visit: Chief complaint: The pt presents XX with f/u XX XX and XX pain. Self-reported. XX – patient's occupation, XX. HPI: **XXXX**. Total PT sessions: XX. Tolerating light duty. Feels XX with XX XX grip. Needs refill on XXXX. Had some intermittent XX in XX in XX XX. Initially. Now resolved. Had MRI of XX and XX-XX on XXXX. Report pending. Patient reports XX pain on XXXX XX XX and XX. XX Pain: The pain is located in the XX XX XX and XX lateral XX. The symptoms occur intermittently. XXXX described XXXX pain as XX in nature. The severity of the pain is XX. The pain radiates to the XX XX. Associated symptoms include XX XX, XX XX and decreased XX ROM. Exacerbating factors include XX movement and XX movement. Relieving factors include ice, XX anti-XX drugs and PT. XX Pain: Pain is located in the XX XX XX, XX XX XX and XX XX XX. The symptoms occur intermittently. XXXX describes XXXX pain as XX in nature. The severity of the pain is XX. Pain radiates to the XX XX. Associated symptoms include decreased

ROM and XX. Exacerbating factors include XX movement, XX XX and lifting. Relieving factors include rest. Patient is taking the meds as prescribed and XXXX is tolerating medication well. Patient has been referred to PT and has attended XX visits since the last visit. XXXX has been working transitional duty and has been adhering to the work restrictions as prescribed. Assessment: XX) Sprain of XX XX (XX.XX); XX) XX sprain (XX.XX). Plan: XX) XXXX.

XXXX – Physician Notes- XXXX: Reason for visit: Chief complaint: The patient presents XX with f/u. Self-reported. XX- Patient's occupation. HPI: XXXX is returning for a recheck of injury(s). Patient reports XX pain on XXXX XX going down XXXX XX XX. The symptoms occur intermittently. XXXX described XXXX pain as XX in nature. The severity of the pain is XX. The pain radiates to the XX XX. Associated symptoms include XX XX, XX XX and decreased XX ROM. Exacerbating factors include XX movement. Relieving factors include rest. Pain is located in the XX XX XX. The symptoms occur intermittently. Assessment: XX) XX of XX XX XX (XX); XX) XX sprain (XX.XX); XX) Sprain of XX XX (XX.XX); 4) XX XX of XX XX joint (M75.51). Plan: XX) XXXX. XX) XX therapy referral, frequency XX x a week for XX weeks. XX) XX referral to evaluate and treat. Return in XX-XX weeks for f/u.

XXXX – Physician Notes- **XXXX**: Consultation. Case Date: **XXXX**. This is a XXXX who has had repetitive XX motion at a **XXXX** which has resulted in XX pain, mainly XX XX pain and XX, occasionally radiating into the XX XX XX, but mainly in the XX side of XXXX XX, that has caused XXXX to be on restricted duty because of the XX pain which is constant. XXXX is taking medication for the pain, **XXXX**. XXXX states that XX therapy and medication have not really helped XXXX and XXXX continues in pain. Assessment: XX sprain/strain. The MRI does not show any significant XX XX, XX at XX. XXXX symptoms are not consistent with XX in my opinion. XXXX has more XX pain consistent with XX XX and has clinical correlation now with XX XX-XX, XX-4 XX XX blocks. If this is successful, we will do XX therapy, also XX XX with XX therapy if the XX XX XX block is successful. Follow up in XX weeks if this has been denied. The patient also understands and wishes to have XX during the XX injection.

XXXX – URA Determination- **XXXX**, as the delegated agent for the insurer, has reviewed the prescribed plan of treatment. Treatment Requested: XX XX XX XX XX Branch (XX) on the XX XX-XX, XX-XX, as outpatient. Determination: XX: Recommended prospective request for XX XX Block XX XX (XX) on the XX XX-XX, XX-XX, as outpatient between **XXXX** be non-certified. Rationale: I attempted to contact **XXXX**. A message was XX with **XXXX**. Records Reviewed. The patient's name is **XXXX**. The date of injury is **XXXX**. The patient complains of XX pain and XX XX pain. The injury occurred secondary to cumulative XX related to **XXXX**. The pain is mostly in the XX XX at XX/XX. XX XX MRI showed mild XX changes at the XX joint. There is pain in the XX XX XX. The Clinical review criteria used to make this determination will be made available upon written request.

XXXX – URA Re-Determination- **XXXX**, as the delegated agent for the insurer, has reviewed the prescribed plan of treatment. Treatment Requested: Reconsideration for XX XX block XX XX (XX) on the XX XX-XX, XX-XX, as outpatient. This is a re-review. Determination: Recommend prospective request for reconsideration for XX XX block XX XX (XX) on the XX XX-XX, XX-XX, as outpatient between **XXXX** be non-certified. Rationale: A peer-to-peer was attempted on XX different occasions to reach XXXX. I XX messages with XXXX. I have not

received a call XX. The claimant is a XXXX who sustained injuries at the XX XX, XX and XX on XXXX. The medical records indicated that the claimant had been complaining of pain in the XX with some XX into the XX area as a result of overuse XX XX. There was no specific injury or incident that brought on XXXX symptoms. The symptoms apparently vary in severity and occurring frequently with remissions and exacerbations. XXXX indicated that when XXXX had pain in the XX area, sometimes radiating to the XX XX area, but mainly in the XX. XXXX had XX therapy and had been on medications. The claimant had x-rays, which revealed some XX. XXXX had an MRI of the XX XX on XXXX, which was essentially a completely normal examination. There was straightening of the normal XX XX suggesting possible XX XX, most common cause was positioning. At the XX-XX level there was a noted XX central XX XX producing effacement of the XX XX not producing any XX dysfunction. At all levels, there were no areas of XX XX. There was no evidence of XX XX XX. There was no evidence of XX XX at any of the XX levels. This appeared to be a XX condition. Reconsideration for XX XX XX XX branch (XX) on the XX XX-XX, XX-XX, as outpatient. At this time, due to lack of documentation to support the request, the request for this reconsideration is not medically necessary.

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

The request for XX XX XX/XX, XX/XX blocks and XX-sided XX XX blocks is denied.

The patient is a XXXX who reports pain in the XX XX and XX XX with XX into the XX XX. XXXX has XX XX therapy and medication. XXXX XX XX MRI demonstrated a XX mm central XX XX at XX-XX. No other pathology was identified in this study. The treating physician has recommended XX-XX and XX-4 XX and XX XX blocks to address XX XX pain, which XXXX felt was consistent with XX XX at these levels.

XX branch and XX blocks are typically performed on patients with XX pain associated with XX XX (XX). The Official Disability Guidelines (ODG) recommends these blocks for patients with XX pain, who do not have XX.

The patient's XX XX MRI demonstrates no evidence of XX XX at these levels. It is unclear from the medical records whether the patient has XX associated with the XX-XX XX.

The requested blocks are not 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**
- ☒ **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)**