Matriarch
CONSULTING SERVICES

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Denial of XX XX Injection – XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This case was reviewed by a board-certified Physical Medicine and Rehabilitation who is considered to be an expert in their field of specialty with current hands on experience in the denied coverage.

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

Upheld (Agree)

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX. In XXXX, the patient had XX performed by XXXX with good results and pain resolved. The patient had recurrence XX pain XX the XX XX in XXXX. XX of the XX showed small XX XX XX with XX. The patient responded well to XX in XXXX. The patient then participated in distance XX and exercise and did well until recurrence in XXXX with XX pain less than XX pain and XX pain. The XX XX pain is in the XX thigh, XX XX into XX and XX XX XX. XX XX pain is in XX XX. Chiropractic was of minimal help. MRI of XX XX dated XXXX showed XX XX changes at XX-XX, generalized XX XX producing moderate to severe XX XX XX at XX-XX. Orthopedic visit by XXXX feels XXXX has a XX XX XX and is requesting conservative treatment with XX XX-XX XX before considering either XX at XX-XX to XX both sides of the XX XX or XX XX-XX with XX-XX device. On XXXX office visit, the patient presented with XX XX pain less than XX XX pain. On a scale of mild to severe, the intensity was described as a XX. The pain was associated with symptoms including XX and XX. The patient denied any XX. Pain was described as XX, XX. No pain medication was being taken at that time. Utilization initial review dated XXXX determined non-certification of XX XX since there was no documentation of failure or completion of conservative treatment, either XX weeks in XX months or an ongoing home exercise treatment plan. Subsequent review dated XXXX non-certified the request because the exam findings documented normal strength, sensation, and reflexes in the XX XX extremities. Successful peer to peer review noted XXXX stated that the patient has clear subjective evidence of XX with pain in the XX XX-XX distribution but agrees that there are no changes in strength, reflexes, and sensation.

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

XX. There is no documentation of supporting physical findings such as XX, XX, or XX deficits suggestive of XX XX. For these reasons, the review of medical records and ODG criteria, the request for XX XX-XX XX XX XX Injection is not medically necessary and appropriate.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

Official Disability Guidelines (ODG)
XX