Professional Associates P. O. Box 1238 Sanger, Texas 76266
Phone: 877-738-4391 Fax: 877-738-4395

Date notice sent to all parties: 11/19/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX XX XX XX injection (XX) with monitored anesthesia

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Orthopedic Surgery
Diplomate of the American Board of Orthopedic Surgery
Fellow of the American Academy of Orthopedic Surgeons
Fellow of the American Association of Orthopedic Surgeons

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

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

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

XX XX XX XX with monitored anesthesia – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX. XXXX examined the patient on XXXX for XXXX XX, XX XX, XX XX/XX, and light XX. XXXX noted XXXX had a XX and XX, glass in XXXX XX XX and XXXX had XX XX pain without radiation. The assessments were a closed XX injury with brief XX, XX, acute XX XX XX pain, acute XX strain, XX sprain/strain, XX XX strain, XX XX strain, and XX-XX strain. The patient was referred for physical therapy in which XXXX attended for XX sessions in XXXX. As of XXXX, XXXX had severe XX XX pain and XXXX pain was unchanged and rated at XX/10. XXXX examined the patient on XXXX. XXXX had XX XX and XX XX pain

and had attended therapy. XXXX was referred for therapy and given a XXXX injection. The patient was reevaluated in therapy on XXXX and attended XX XX sessions through XXXX. A XX XX was then obtained on XXXX and revealed a XX XX XX central XX at XX-XX that extended into the XX fat and indented the XX XX. There was associated mild XX XX XX XX. XXXX followed-up with the patient on XXXX and XXXX symptoms were stable. XXXX wished to try work again and XXXX was released to full duty at that time. On XXXX examined the patient for XXXX for the XX XX XX pain. XXXX had XX XX extremity symptoms in an XX distribution. XX and XX walking were XX and there was no evidence of weakness at XX-XX. XX were 0 in the XX XX XX. XX was positive XX for XX XX pain and on the XX for radiating pain. A XX XX XX at XX-XX was recommended at that time, which an adverse determination was provided for on XXXX XXXX reevaluated the patient on XXXX. XXXX had done well the last XX weeks and they discussed referral for XX and XX. XXXX was released to full duty at that time. On XXXX, another adverse determination was submitted for the requested XX XX XX XX.

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

XXXX. XXXX sustained multiple strains and XX, which have subsequently resolved, except for continued XX XX pain. The XX scan performed on XXXX of XXXX XX XX reported a XX at XX-XX. XXXX was subsequently evaluated by XX XX XXXX, who has recommended the requested procedure, despite the absence of clinical findings of XX radiculopathy. The request was non-certified on initial review by XXXX. XXXX non-certification was upheld on reconsideration/appeal by XXXX. Both reviewers cited the evidence based Official Disability Guidelines (ODG) as the basis of their opinions. It should be noted that the screening criteria and treatment guidelines, XX XX Chapter, criteria for use of XX include the following: XX

The request for the XX does not meet the ODG criteria as outlined above. The XX XX diagnosis is not supported by the medical documentation reviewed. In addition, the evaluation by XXXX noted that for the last XX weeks the patient had done XX and the patient was referred for XX and a possible impairment rating. Therefore, the requested XX XX XX XX with monitored anesthesia is not medically necessary, reasonably related, or supported by the evidence based ODG and the previous adverse determinations should be upheld at this time.

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 XX XX PAIN**

☐ **INTERQUAL CRITERIA**

X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **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)**