Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: NOVEMBER 20, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Medical necessity of proposed XX Injection, XX XX (XX)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

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

XX Upheld (Agree)

☐ Overturned (Disagree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX. The claimant was diagnosed with a XX XX pain. Surgery included XX XX XX with XX, XX, XX, XX repair, and XX of the XX (XX). Treatment had included XX therapy. Medication had included XXXX. An evaluation on XXXX, noted the claimant complained of XX XX pain rated XX/10 on the visual analog XX. The current medication was XXXX. On physical examination, XX XX XX XX was normal. Sensation was XX to XX XX. There was limited range of motion of the XX XX. XX and XX were positive to the XX XX.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.
RATIONALE: The request was previously noncertified by XXXX, as the outcome of the postsurgical XX therapy was not noted, in order to support the request. In addition, it was stated that there was a prior adverse determination for a XX XX injection on XXXX. No additional documentation was submitted. The request remains noncertified. The guidelines require failure of XX levels of care. There is no documentation provided supporting failure of XX levels of care with a XX XX program, XXXX, as required by the guidelines. Also, there is no documentation

that the pain interferes with the claimant's functional activities, limiting work. Therefore, medical necessity for a XX XX XX injection has not been established. The request is non-certified.

Official Disability Guidelines
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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

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

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

XX 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)