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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX Injection @ XX XX-XX, XX-XX, #1 and XX Sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Orthopaedic Surgery

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX. XXXX was diagnosed with XX XX, XX, and XX XX with XX. XXXX evaluated XXXX for a follow-up. XXXX reported that the XX-XX XX joint injection did not give XXXX any relief. XXXX continued to have XX XX and XX pain. XXXX had so much pain so XXXX had moved XXXX appointment up earlier. The previous XX XX injections and XX at XX-XX and XX-XX seemed to control XXXX pain. The XX pain was rated at XX/10. On examination, XXXX had XX tenderness XX and tenderness in the XX. An XX of the XX XX dated XXXX showed broad-based XX-mm central / XX paracentral XX XX with slight XX fragment XX at the XX-XX level resulting in XX XX flattening in the XX XX XX narrowing to XX mm and broad-based XX.XX-mm central XX XX complex at the XX-XX level resulting in XX XX flattening in the XX canal diameter XX to XX mm area, and a XX-mm far XX XX XX XX complex at the XX-XX level, which resulted in XX XX diameter narrowing in the XX to XX mm. There was also XX, XX greater than XX, neural XX XX present. A XX-mm central XX XX at the XX-XX level was noted. New plain x-rays showed XX XX at the XX-XX level. The treatment to date included medications (XXXX), XX XX-XX XX joint injection under XX guidance on XXXX without relief, XX XX injections and XX XX at XX-XX and XX-XX in XXXX with relief and repeat XX XX XX in XXXX with relief. Per a utilization review decision letter dated XXXX, the request for XX XX injection at the XX XX-XX and XX-XX levels was denied. Rationale: "The claimant has reportedly had good results from prior XX XX. It is unclear why XX injection would be repeated. Therapeutic injections are not recommended by ODG." Per a reconsideration review decision letter dated XXXX, the appeal for XX XX injection at the XX XX-XX and XX-XX

levels was not approved. Rationale: "The proposed treatment plan is outside of treatment guideline recommendations. There is no indication for repeat diagnostic XX injections. Consideration may be given to repeating the XX with appropriate documentation per the ODG but repeat of XX XX is not medically indicated." The clinical basis for the denials was as follows: "The current request is for XX-4 and XX-XX XX. The patient is a XX injury with date of injury in XXXX. XXXX has had excellent response to several previous XX XX branch XX. It has been over XXXX since XXXX last treatment. Based upon this, there is no indication for repeat diagnostic XX injections. Consideration may be given to repeating the XX with appropriate documentation per the ODG but repeat of XX XX is not medically indicated. Recommend denial."

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

Based on the clinical information provided, the request for XX XX injection at the XX XX-XX and XX-XX levels is not recommended as medically necessary. Per a utilization review decision letter dated XXXX, the request for XX XX injection at the XX XX-XX and XX-XX levels was denied. Rationale: "The claimant has reportedly had good results from prior XX XX. It is unclear why XX injection would be repeated. Therapeutic injections are not recommended by ODG." Per a reconsideration review decision letter dated XXXX, the appeal for XX XX injection at the XX XX-XX and XX-XX levels was not approved. Rationale: "The proposed treatment plan is outside of treatment guideline recommendations. There is no indication for repeat diagnostic XX injections. Consideration may be given to repeating the XX with appropriate documentation per the ODG but repeat of XX XX is not medically indicated." The clinical basis for the denials was as follows: "The current request is for XX-XX and XX-XX XX. The patient is a XX injury with date of injury in XXXX. XXXX has had excellent response to several previous XX XX branch XX. It has been XXXX since XXXX last treatment. Based upon this, there is no indication for repeat diagnostic XX injections. Consideration may be given to repeating the XX with appropriate documentation per the ODG but repeat of XX XX is not medically indicated. Recommend denial." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records indicate that the patient has undergone prior XX injections at the requested levels followed by XX XX procedures. The Official Disability Guidelines do not support repeat XX injections, and there is no clear rationale provided to support XX injections after successful XX.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the request is upheld.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL