MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

DATE NOTICE SENT TO ALL PARTIES: 11/18/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of XX XX XX injections (XX) and XXXX injections (XX).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Anesthesia and Pain Management. The reviewer has been practicing for greater than 10 years.

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

☒Upheld (Agree)

☐Overturned (Disagree)

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

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of XX XX XX injections (XX) and XXXX injections (XX).

PATIENT CLINICAL HISTORY [SUMMARY]:
Patient presents on XXXX for XX XX. Review of systems XX. Examination of the XX or XX revealed XX with no masses and with good range of motion (ROM). Recent and remote XX were intact to XX with no evidence of XX XX. The XX span and XX were normal. Affect was appropriate. Examination of the XX nerves revealed XX movements were intact with no XX. There was no XX or conjunctival dysfunction. There was no facial weakness or asymmetry. The hearing was intact to voice. There was no dysarthria. Motor examination revealed movements of all XX were equal. The unstressed gait was normal. On XXXX claimant had at least XX fewer XX days since starting XXXX. The duration of each XX had declined as well. Each XX prior to XXXX caused significant disability. There had been no emergency room visits since the last injection. XX. The claimant was given XX greater XX, XX XX, XX XX, XX XX

XX XX XX and XX trigger point injection. On XXXX claimant was given XX greater XX, XX XX, XX XX, XX XX XX XX XX and XX trigger point injection.

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

XX XX XX injections: ODG XX (updated XX)

Greater XX XX XX (XX): Under study for use in treatment of primary XX.
Studies on the use of greater XX XX XX (XX) for treatment of XX and cluster XX show conflicting results, and when positive, have found response limited to a short-term duration. The mechanism of action is not understood, nor is there a standardized method of the use of this modality for treatment of primary XX. A recent study has shown that XX is not effective for treatment of chronic tension XX. The XX may have a role in differentiating between XX XX, XX XX, and tension-XX.

Based on the records submitted and peer-reviewed guidelines this request is non-certified. ODG states that Greater XX nerve XX (XX) is under study for use in treatment of primary XX. Studies on the use of greater XX XX XX (XX) for treatment of XX and cluster XX show conflicting results, and when positive, have found response limited to a short-term duration. The claimant has chronic XX XX and XX XX. The claimant was given multiple XX greater XX, XX XX, XX XX, XX XX XX nerve XX and XX trigger point injection, last one done on XXXX. However, the response to the most recent injection has not been documented. In addition, the guidelines do not overwhelmingly support these injections. Therefore, the request is not medically necessary 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 LOW BACK 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)**