AccuReview

An Independent Review Organization
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October 19, 2018 Amended October 30, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board certified in Anesthesiologist with over 15 years of experience.

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

☒ Upheld (Agree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX: Office Visit dictated by XXXX. CC: recurrent XX and XX XX pain XX related injury and XX surgical procedures. XX and XX XX pain XX related injury. DX: possible XX XX, multilevel XX with XX. TX: revision XX and instrumented XX, XX and XXXX. Claimant continues with XX pain and XX pain located on the XX side. XXXX has had XX culminating in a XX status post a work-related injury. Pain described as XX XX pain radiating to XXXX XX XX and XX extending with XX and XX to XXXX XX XX and hand. XXXX describes subjective XX about XXXX extremities as well as XX and XX on the XX in the XX distribution most closely. XXXX symptoms are XX in intensity and XX % XX and XX% XX, aching and burning in character. Recurrent treatments have included use of XX, XX, XX and activity restriction and symptoms persist. Medications: XXXX. Assessment: Possible XX XX s/p work related injury and XX procedures. Multilevel XX with severe XX. Recommend XX of the XX well as an XX of the XX extremities.

XXXX: Office Visit dictated by XXXX: XX pain. The claimant complains of XX pain. XXXX is here for medication which does provide adequate relief enabling XXXX to function and need minimal assistance with XX and it helps XXXX. XXXX is having problems with extension and almost passes our and decrease sensation XX XX. Current treatment includes: XX manual medicine care and XX. The current treatment is providing little relief of current symptoms. Reported associated XX. Claimant has completed XX weeks of conservative care prior to this visit but not limited to XX without improvement. PE: XX: XX tenderness: XX. ROM limited

in limited XX moderately due to pain. Impression: XX and XX; post-operative XX; XX; XX; XX; XX. Recommendations: activity modification to accommodate XX. Medication prescribed: XXXX.

XXXX: Office Visit XXXX: recurrent XX and XX XX pain. : XX s/p work related injury and XX procedures. XX, multilevel DDD. Claimant described some XX occur when XXXX extends XXXX XX, encouraged to follow up XX further evaluation. Relative to the XX, concerned XXXX may have some symptoms that every from XXXX; send for XX. Will also request XX done simultaneously.

XXXX: XX dictated by XXXX. Impression: Post-surgical and XX are noted.

XXXX: XX dictated by XXXX. Impression & Recommendations: 1. Delayed XX on both sides, 2. The XX. The amplitudes of the XX are fairly large and symmetric, 3. XX, 4. XX muscles. There is evidence of focal slowing in conduction velocity across the XX segment. XX of the XX XX responses are XX stimulation sites with no evidence of any significant conduction block seen in either side. 5. Needle examination surveyed multiple XX receiving their XX from the XX XX roots on both sides including XX half XX XX on the XX. XX was deferred in light of previous XX surgery. All muscles tested were normal in their insertional activity. There was no evidence of any abnormal spontaneous activity. All motor units observed in the muscle examined were normal in their XX. Impression: XX, XX of XX A. mild, B. XX in XX XX segment with XX for the across XX velocity, C. no XX XX. XX at the XX: moderate, XX XX, both XX and XX affected. Medications added: XXXX.

XXXX: XX dictated by XX: no significant XX are noted. XX appear to be adequately filled.

XXXX: UR performed by XXXX. Reason for denial: Regarding the request XX; XX XX pain. The physical exam also revealed XX XX, and extension XX with radiating pain. However, XX is not recommended per guidelines. Request is not medically necessary.

XXXX: UR performed by XXXX. Reason for denial: The request was previously noncertified as the procedure was not recommended by the guidelines and there was a lack of documentation to support XX. No additional documentation was submitted to support the request. The previous noncertification is supported. According to the guidelines, XX is not recommended given the serious risks of the procedure and the lack of quality evidence for sustained benefit. If performed, the guidelines state there must be evidence of XX on clinical examination and diagnostic imaging. There is no evidence of XX on clinical examination and diagnostic imaging at the requested level of injection.

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

Based on the records submitted and peer-reviewed guidelines, the previous noncertification is upheld. Per ODG, XX is not recommended given the serious risks of the procedure and the lack of quality evidence for sustained benefit. If performed, the guidelines state there must be evidence of XX on clinical examination and diagnostic imaging. There is no evidence of XX on clinical examination and diagnostic imaging at the requested level of injection. This request was

previously noncertified as the procedure was not recommended by the guidelines and there was a lack of documentation to support XX. No additional documentation was submitted to support the request therefore, the request for XX XX XX with XX with monitored anesthesia is not medically necessary and therefore is non-certified.

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)**