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DATE OF REVIEW: 9/19/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Authorization for outpatient XX XX XX injection therapy under fluoroscopy with intravenous (IV) sedation at L4-5 and L5-S1.

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

M.D., Board Certified in Physical Medicine and Rehabilitation with sub-specialty in Spinal Cord Injury Medicine and Pain Medicine.

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)

I have determined that the requested is medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XXXX and has a history of a work injury occurring on XXXX. XXXX. Treatments referenced include a XX epidural injection at XX, which provided XX-XX% relief of pain lasting for six weeks. XXXX underwent a XX fusion at XX on XXXX. A CT diagram prior to surgery in XXXX showed findings of multilevel degenerative XX joint XX. A postoperative CT scan on XXXX showed expected postoperative findings. XXXX began physical therapy in XXXX with XX sessions recently authorized in XXXX. XXXX was seen for an initial pain management evaluation on XXXX. XXXX had XX persistent axial XX pain radiating to the XX XX area and occasionally into the buttocks and XX thighs. XXXX also had XX XX pain above the level of XXXX prior surgery which had persisted. Urine drug screening at intake was positive for XXXX. Physical examination findings included a height of XXXX and weight reported at XXXX. XXXX is described as well-developed and well-built.

XXXX appeared to be in moderate distress as XXXX was walking with an antalgic limp and gait. XXXX had increased XX paraspinal muscle tone and there was severe trigger point tenderness. XXXX had exquisite XX tenderness at XX and XX above the level of XXXX surgery, which was aggravated mostly to the left with side bending and extension. Additionally, XXXX had weakness of XXXX hip flexors. Diagnoses included mechanical XX pain syndrome above the level of XXXX fusion and secondary myofascial pain. There was a review of core strengthening exercises. Correspondence dated XXXX references that the claimant had undergone a procedure more than a year before, prior to XXXX XX surgery. XXXX had ongoing pain rated at 7-8/10. Physical examination findings appear unchanged. XXXX is currently requesting XX XX injections.

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

ODG criteria for the use of XX blocks / injections for XX mediated pain include patients with XX-XX pain that is non-radicular and where there is documentation of failure of conservative treatments. No more than two XX joint levels are to be injected in one session. Diagnostic XX blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. In this case, injections are being planned above the level of the claimant's fusion. XXXX has physical examination findings and complaints consistent with XX mediated pain. Conservative treatments have been provided, including recent physical therapy. XXXX meets ODG criteria for the requested XX joint injections. ODG: XX XX-XX & XX (XX & XX), Diagnostic XX joint blocks (injections).

Therefore**,** I have determined the requested is medically necessary for treatment of the patient's medical condition.

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 XX XX XX 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)**