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Date notice sent to all parties: 10/03/18

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:
Board Certified in Orthopedic Surgery

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

X Upheld (Agree)

☐ Overturned (Disagree)

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

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

XX – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX had a phone consultation with the patient on XXXX and XXXX was status post XX fusion with XX on XXXX. XXXX had an injection on XXXX and was 60% better since the last visit. XXXX were prescribed. On XXXX had another phone conversation with the patient who stated XXXX had no leg pain. XXXX had been unable to travel for XXXX postoperative visits, as XXXX had hurt XXXX knee. XXXX wanted to discuss repeating the XX. Physical therapy was also prescribed. On XXXX, the patient had improved range of motion and XX tenderness. Straight leg raising was negative. Therapy was prescribed and XXXX were refilled. XXXX reported falling XX weeks prior in XXXX and had XX XX pain. XXXX was XXXX. XXXX lower XX to XX XX pain did not radiate. XXXX then reexamined the patient on XXXX. The chief complaint was lower XX and XX XX XX problems. XXXX noted XXXX symptoms were

better and different. XXXX was doing 40% better and XXXX claimed weakness and had pain rated at 6/10. XXXX was doing somewhat better but stated that overall XXXX was very limited with activities. XXXX and had painful XX range of motion. XXXX was unable to do XXXX due to XXXX previous XX surgery and XXXX needed a note. XX XX-XX and XX-XX XX injections were recommended. A XXXX was recommended and XXXX were refilled. On XXXX, a utilization review request form was submitted by XXXX for XX XX-XX and XX-XX XX injections. On XXXX. provided an adverse determination for the requested XX injections. On XXXX. also provided an adverse determination for the requested XX-XX and XX-XX XX injections. The patient followed-up with XXXX. XXXX low XX symptoms were noted to be worse and XXXX noted XXXX had weakness. XXXX rated XXXX pain at 5/10 and stated XXXX was hurting in the XX to low XX more frequently. On exam, XXXX had XX XX paravertebral tenderness and painful range of motion. No neurological exam was documented. XXXX noted the XX injections had been denied twice and they were in the review process. XXXX were refilled at that time.

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

XX joint injections are designed to be used on mobile facets. The purpose of XX joint injections is to test whether a XX rhizotomy or denervation of the facets would be useful in relieving pain. In XXXX note of XXXX noted that the areas that XXXX wished to have injected, XX-XX and XX-XX, were within the boundaries of a previously performed fusion. Performing a XX injection at these non-mobile joints would not provide any benefit from either the injection or the subsequent rhizotomy. Furthermore, it should be noted the ODG states that XX blocks should not be performed in patients who have had a previous fusion at the planned injection level. The patient is fused at the level XXXX has requested be included in XXXX request for XX injections. In my medical opinion, based upon the ODG and clinical criteria, there is no specific utility in using XX injections in this situation. Therefore, the requested XX XX-XX and XX-XX XX injections are not medically necessary, appropriate, or in accordance with the ODG and the previous adverse determinations should be upheld 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 XX PAIN**
- ☐ **INTERQUAL CRITERIA**
- **X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- **X 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)**