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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX XX Injection at XX under Fluoroscopy with IV Sedation

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

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]: This case involves a now XXXX with a history of an occupational claim from XXXX. The mechanism of injury is detailed XXXX. An MRI of the XX XX on XXXX, documented a XX disc bulge at this level with no XX XX stenosis or neuroforaminal encroachment at the XX-XX level. And XX report on XXXX, documented no evidence of XX XX or XX. The reevaluation of XXXX, documented the patient had continued XX XX pain. The patient reported pain in the XX when stretching the XX upper XX. On physical examination, the patient had decreased range of motion to the XX XX. The current diagnoses are documented as status post XX shoulder arthroscopy, probable evolving adhesive XX, XX shoulder XX syndrome, a shoulder XX, a shoulder sprain/strain, a XX XX sprain/strain, a XX XX, and a XX hip/thigh strain. The treatment plan included XX XX XX injection, continue with physical therapy, and a follow- up for reevaluation in 3-4 weeks.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
According to the provided documentation, the patient had continued XX pain despite conservative management with physical therapy, medication management, and activity modification. On physical examination, the patient had a decreased range of motion to the XX XX. This request was previously denied given there was limited evidence the patient has failed all indicated conservative management and there was insufficient documented objective findings to support the requested XX XX injection for this patient. The submitted documentation did not provide clear evidence of focal motor weakness, sensory loss, or reflex changes on examination

and imaging and XX testing did not confirm nerve root compression at the XX-XX level for this patient. Guidelines do not recommend XX XX XX injections and there were no exceptional factors provided for review to support this request beyond guideline recommendations. There was no evidence of anxiety to support sedation with an XX XX injection for this patient. There were no exceptional factors provided for review to support this request beyond guideline recommendations. As such, the medical necessity of this request was not established for this patient.

Based on the above documentation, the requested XX XX XX Injection at XX-XX under Fluoroscopy with IV sedation remains not medically necessary and the review outcome 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

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, XX& Upper XX Chapter, XX XX injection (ESI)