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An Independent Review Organization

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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:

Pain Medicine

REVIEW OUTCOME:

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

- | | |
|---|--------------------------------|
| <input type="checkbox"/> Overturned | Disagree |
| <input type="checkbox"/> Partially Overturned | Agree in part/Disagree in part |
| <input checked="" type="checkbox"/> Upheld | Agree |

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a XXXX with a history of an occupational claim from XXXX. The mechanism of injury was not detailed in the information provided for review. The patient'XX diagnoses included XX or XX, and XX. The patient XX treatment history included medications, trigger point injections, surgery, XX, and XX branch blocks followed by XX. The patient underwent an MRI on XXXX. It identified multilevel degenerative changes most prominently in the region without any evidence of acute osseous or abnormalities. The patient was evaluated on XXXX XX pain. Objective findings included painful range of motion with extension and flexion and tenderness to palpation of sacroiliac joint. The patient was provided trigger point injections at that appointment. The treatment plan included a refill of medications. A request for XX through XX XX branch blocks was submitted. This request was previously reviewed and received an adverse determination as the clinical documentation did not support XX-XX XX joints treatment as a standard of care. The request was appealed and again determined to be noncertified. An independent review was requested.

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

The Official Disability Guidelines recommend XX branch blocks to confirm a diagnosis of XX arthropathy and to determine the appropriateness of advancing treatment to a radiofrequency ablation. The submitted clinical documentation submitted for review does indicate that the patient has multilevel degenerative changes of the lumbar spine. Additionally, the clinical documentation submitted for review does indicate that the patient has painful range of motion consistent with XX arthropathy that is not trending towards improvement with nonoperative treatment. The patient does have painful range of motion indicative of XX injections. However, the treatment history included a XX-sided XX through XX a repeat XX branch blocks. It is unclear why confirmatory testing is medically necessary for this patient. There is no documentation of that the treatment plan is to advance to a radiofrequency ablation. As such, the requested XX XX through XX branch block is not medically necessary. The previous determination 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), XX, Low XX Chapter, XX joint diagnostic blocks (injections)