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Date: 10/12/2018 3:52:10 PM CST

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX joint injection

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 ocular patient will claim from XXXX. The mechanism of injury was not detailed in information provided for review. The current diagnoses were documented as XX radicular pain and XX pain. Office note visit dated XXXX, the patient was seen with continued XX pain with standing and walking and increased activity. The patient described the pain as stabbing and rated at 7 on a scale of 10. On a physical examination, the patient remained extremely tender to palpation over the XX XX joint. The patient had a positive XX XX and compression test. The patient had a negative straight leg test on the XX. Motor strength was 5/5 throughout and sensation was grossly intact throughout. The treatment plan included XX XX joint injection. This case was appeal but that was denied due to 2 out of 5 tests that were performed were positive and the request does not meet guideline criteria on XXXX.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Official Disability Guidelines do not recommend XX Joint Injections. There is no further definitive treatment that can be recommended based on any diagnostic information potentially rendered (as XX therapeutic XX injections are not recommended for XX pathology). The patient remained extremely tender to palpation over the XX XX joint. The patient had a positive XX XX and compression test. The patient had a negative straight leg test on the XX. Motor strength was 5/5 throughout and sensation was grossly intact throughout. Per guidelines the requested service is not recommended.

Therefore, the request for a XX XX Joint Injection is not medically necessary and the decision 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 BACK 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, Hip and Pelvis Chapter/ XX injections, diagnostic