AccuReview

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[Date notice sent to all parties]: October 9, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
1 XX XX Block at XX/XX, XX/XX Levels XX Branch of the XX XX XX XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board certified in Anesthesiologist with over 15 years of experience.

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

☒ Upheld (Agree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who sustained a work-related injury on XXXX

XXXX: Physical Therapy Daily Note dictated by XXXX. Assessment: The claimant exhibited increased tone present in XX along with pain when palpating XX. XXXX did report some reduced pain in XXXX XX along with improved XX mobility after performing PPUs. XXXX will benefit from skilled PT to improve strength and mobility XX for work.

XXXX: Physical Therapy Daily Note dictated by XXXX. Functional Limiting Reporting: the assigned functional limitation and severity modifier reflects the claimant's current and projected percentage of functional impairment based on standardized tests and measures as determined. Lan: Continue therapy for reducing impairments and improving functional performance, increasing ROM and strength to promote functional mobility, body mechanics training to prevent exacerbation of injury, achievement of preinjury status and increasing weight-bearing activities.

XXXX: XX MRI dictated by XXXX. Impression: Signal changes in the body of XX may represent marrow edema related to previous trauma without definite evidence of fracture and no other bony abnormalities are seen. The XX contents and XX structures are normal. There is no XX XX at any level throughout the XX region and no other compromise of the XX XX or XX XX is seen.

XXXX: XX MRI dictated by XXXX. Impression: There is no acute osseous lesion and the XX XX and XX structures are normal. A broad-based, XX mm XX XX at XX-XX slightly compresses the XX sac and causes slight compromise of the XX XX and right XX foramen. There is no other XX XX or other compromise of the XX XX or XX XX throughout the XX region and no other abnormalities are seen.

XXXX: Status Report: Follow-Up Evaluation dictated by XXXX. CC: lower XX pain that wakes XXXX up at night, XX is stiff though better. Current medications: XXXX. PE: XX XX: muscle spasms along the XX remained the same, trapezius muscle spasm noted XX with tenderness to palpation. XX XX: muscle spasms along the XX muscles remain the same with tenderness over XX facets. DX: Sprain of ligaments of XX XX, Sprain of ligaments of thoracic XX, Sprain of ligaments of XX XX, Other internal derangements of Right knee, Contusion of unspecified front wall of thorax. Recommendations: No physical therapy at this time, XXXX, advised to follow-up with PCP for positive ROS, MRI reviewed with claimant, XXXX may benefit from XX XX block and XX XX, referral to the XX XX XX block.

XXXX: Peer Review at XXXX dictated by XXXX. Reason for denial: The claimant has current complaints of XX and low XX pain that have decreased but not completely resolved with PT and medication management. The claimant has pre-existing and degenerative conditions within the XX XX and XX XX that are likely the cause of XXXX current complaints, as XXXX compensable injury should be resolved at this point. Sprain/strain injuries typically resolve within XX-6 weeks. Therefore, the claimant's current complaints are unrelated to the compensable injury. No additional treatment would be indicated XX the compensable injury including PT, pain management, injections, diagnostic studies, referrals, office visits, DME, work hardening/conditioning, surgery, or prescription medications, as the compensable injury has resolved. The claimant has undergone XX sessions of PT, ODG recommends up to XX sessions of PT over XX weeks for XX and XX sprain/strains. Therefore, no additional PT is warranted. None of the claimant's pre-existing conditions were aggravated, exacerbated, or accelerated by the work injury. There were no new structural changes or damage on imaging studies to indicate an aggravation or exacerbation of these conditions. Additionally, the mechanism of injury and objective physical examination findings are not consistent with an aggravation of these pre-existing conditions.

XXXX: Office Visit dictated by XXXX. CC: XX pain, low XX pain. Assessment: Sprain of ligaments of XX XX, Sprain of ligaments of XX XX. Plan: XX XX branch of the XX XX XX block XX/XX level, XX/XX level XX branch of the XX XX on the XX x1.

XXXX: UR performed by XXXX. Reason for denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request if non-certified. Per guidelines, XX joint diagnostic blocks are recommended prior to XX neurotomy. The clinical presentation should be consistent with XX joint pain, signs & symptoms. Upon review of the medical reports submitted, the claimant presented with XX tenderness in a XX area noted on the XX. There was XX pain on XX rotation/extension/flexion and palpation and axial loading in the XX XX XX. The current plan of care was for a XX XX branch of the XX XX XX block XX/XX level and XX/C4 level XX branch of the XX XX on the XX XX 1 and noted that is the XX branch blockade is successful, radiofrequency ablation (RFA), followed by physical therapy will be requested. Additionally, although it was noted that the claimant had XX sessions of physical therapy, there was no actual therapy notes/evaluation to validate failure of conservative treatment. Pending this, the request cannot be fully supported.

XXXX: Office Visit dictated by XXXX. CC: XX pain, low XX pain and headaches. XXXX is able to stand for less than 30 minutes, able to sit for less than 30 minutes, able to walk for less than 30 minutes with pain level XX-6/XX, at worst XX-9/XX and at best XX-6/XX. Claimant reported pain feels like dull, throbbing and aching pain and only alleviated by lying down on XX with feet elevated. DX: Sprain of ligaments of XX XX, Sprain of ligaments of XX XX. Plan: follow-up with referring physician. The claimant has a degree of anxiety about needles and understands the importance to minimize sudden movements during procedure and expresses a mental and/or a psychological impediment to not having a degree of relaxation medication.

XXXX: UR performed by XXXX. Reason for denial: Based on the clinical information submitted for this review and using the evidence-based peer-reviewed guidelines referenced below, this request is not medically necessary. In light of this presenting issues and in the absence of pertinent extenuating circumstances that would

require deviation from the guidelines, the appeal request for 1 XX XX Block at XX/XX, XX/XX Levels XX Branch of the XX XX XX XX is not medically necessary as there was no objective evidence of a decreased range of motion, particularly with extension and rotation.

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

Based on the records submitted and peer-reviewed guidelines, the previous non-certification determinations are upheld and agreed upon. Per ODG, XX blocks are not recommended. In addition, after reviewing the medical records and documentation provided in this case, there is no objective evidence of a decreased range of motion, particularly with extension and rotation. Therefore, the request for 1 XX XX Block at XX/XX, XX/XX Levels XX Branch of the XX XX XX XX between XXXX is not medically necessary and denied.

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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**
- ☒ **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)**