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Date notice sent to all parties: 09/05/18

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:

Certified by the American Board of Anesthesiology
Certified by the American Board of Anesthesiology/Pain Management
Fellowship Trained in Pain Management

REVIEW OUTCOME:

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

- 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]:

The patient was allegedly injured on XXXX. At the time, the patient was a XXXX. XXXX was seen at XXXX, one month after the alleged event. There is no documentation as to any prior medical evaluation or treatment the patient received. XXXX complained of a pain level of 7/10. XXXX height was XXXX and weight was XXXX pounds for a calculated BMI of XXXX. XXXX complained of pain in the XX radiating to the XX shoulder, XX arm, and XX, as well as XX XX pain. The patient complained of no other associated symptoms except for XX pain radiating to the XX XX and XX XX pain and pain radiating to the XX arm and XX as well as XX XX XX pain with a pain level of XX/XX in the XX XX. Physical examination documented no tenderness and normal palpation of the XX shoulder with limited range of motion in all planes, but normal strength. In the XX XX, there was palpatory tenderness and "XX muscle spasms" with painful range of motion in all planes. The XX XX demonstrated XX and XX XX tenderness and decreased range of motion in all planes. Neurologic examination was entirely normal with normal sensation, reflexes, and strength in the XX and XX XX. XXXX recommended an orthopedic evaluation and physical therapy. The patient returned to XXXX, some XX days later, complaining of XX pain radiating to the XX XX and XX XX pain worse on the XX than the XX. XXXX noted that the patient's XX did not want the patient to undergo physical therapy. Physical examination was the same as five days before. On XXXX, the patient was seen by XXXX, complaining of an XX/XX level of pain and no benefit from prescribed XXXX. Physical examination was still the same with all of the same non-specific findings and painful range of motion in all planes. No medications were prescribed XX XX XX XX XX. XXXX followed-up with the patient on XXXX documenting the same ongoing XX/XX pain level and pain now primarily in the XX XX. Physical examination was essentially identical to all previous visits. XXXX continued XXXX.

XXXX then followed-up with the patient on XXXX noting no change in XXXX pain and the same moderate XX XX pain. The same non-specific physical examination findings in the XX, XX XX, and XX were documented, as well as painful ranges of motion in all planes in the XX and XX XX. XXXX continued XXXX despite the fact that the patient had indicated it was of no benefit and recommended referring XXXX to a special physical therapy unit at the XXXX. On XXXX, XXXX followed-up with the patient noting XXXX had undergone one session of physical therapy. XXXX documented the same "moderate" XX XX pain and same non-specific physical examination findings. On XXXX, XXXX evaluated the patient noting that XXXX had undergone an XX XX XX XX XX previously on XXXX. XXXX complained of "XX" in XXXX XX XX with no tingling and no radiating pain. XXXX noted that the patient was not happy that an MRI scan was not being ordered stating that XXXX had "no acute findings on examination or the x-rays today for the need of MRI." XXXX noted that XXXX ordered x-rays, but that XXXX refused to have those done. Physical examination documented negative straight leg raising, full XX range of motion, and normal neurological examination. XXXX followed up with the patient on XXXX

noting XXXX had now completed two physical therapy sessions. XXXX noted XXXX ongoing "moderate" XX XX pain and the same nonspecific physical examination findings as before, specifically noting normal neurologic findings of normal sensation, strength, and reflexes XX in the XX and XX XX. XXXX started XXXX on XXXX and ordered an MRI scan. On XXXX. XXXX noted that the MRI scan had been denied after a peer-to-peer review based on the patient having no evidence of XX and that XXXX had not completed physical therapy. On XXXX, XXXX followed up with the patient noting XXXX pain level of XX/XX and XXXX request for "XX medication." XXXX now complained of alleged new symptoms of radiating pain down XX XX to the XX with numbness in XX XX. XXXX noted XXXX had completed three physical therapy sessions. Physical examination still documented, however, no neurologic deficits with normal strength, sensation, and XX in XX XX XX. XXXX refilled XXXX and referred the patient for pain management.

On XXXX, the patient the returned to XXXX who noted XXXX ongoing lumbar pain level of XX/10 and a request for "more medication." XXXX noted that review of systems was "negative" except for XXXX XX pain. Physical examination again documented only non-specific findings with no neurologic deficits whatsoever. XXXX refilled XXXX. On XXXX evaluated the patient for a pain management consultation. XXXX noted XXXX had completed three sessions of physical therapy and was taking XXXX without benefit. Physical examination documented non-specific decreased XX range of motion in all planes in the XX XX, XX XX-XX "pain," and what appears to be a negative straight leg raising test. XXXX ordered a XX MRI scan and recommended more physical therapy. On XXXX, the XX MRI scan was performed. It demonstrated XX mm XX-XX and XX-XX XX XX with no central XX or XX narrowing at any level and no evidence of XX XX or XX disease. On XXXX followed-up with the patient for XXXX ongoing XX XX pain. Physical examination documented non-specifically decreased XX range of motion in all planes, XX XX-XX XX tenderness, and "XX" straight leg raise. XXXX recommended XX XX-XX XX XX blocks, which were performed on XXXX under XX sedation. The patient returned to XXXX reporting "XX% relief." Physical examination documented non-specific increased range of motion and XXXX recommended XX XX-XX XX XX. Two separate physician reviewers recommended non-authorization of that request citing the Official Disability Guidelines (ODG). On XXXX again followed-up with the patient documenting that XXXX now, again, had an onset of repeat decreased range of motion in all XX planes and again XX XX-XX "pain." XXXX started XXXX on XXXX and again recommended XX XX which, as stated above, was also denied citing ODG guidelines.

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

According to the documentation, XXXX performed the XX XX blocks at XX-XX XX on XXXX with the patient receiving unknown amounts of XX sedation medication. The ODG guidelines specifically state that such a practice may “be grounds to negate the results of diagnostic block” and that XX sedation should “only be given in cases of extreme XX.” There is no documentation reviewed or provided of the patient having such “XX XX” that would necessitate the use of XX sedation for the XX XX blocks. The use of XX sedation for XX XX blocks can certainly cause a false positive result of a block, as the medications used for XX sedation often include XX which, in and of themselves, are analgesic and provide pain relief, thereby possibly causing the pain relief that occurred, negating the effect of the XX XX block. In other words, depending on the XX sedation agents that were used, it is entirely possible that the results of the XX XX blocks were due to the XX sedation agents used and not the XX XX blocks themselves. This is why the ODG strongly recommends against such a practice except in “extreme cases” which, apparently, this case is not. XXXX has not provided any anesthesia record or description of the XX sedation agents that were utilized that would otherwise make it possible to determine whether the XX sedation could have caused a false positive medial branch block result. Absent such data, I agree with the physician reviewers who recommended non-authorization of the request for XX XX XX block XX. In addition, not only do the ODG guidelines strongly recommend against the use of XX sedation for this procedure, they also indicate that additional criteria including documentation of failure of conservative treatment, including home exercises, physical therapy, and non-steroidal anti-inflammatory medications, need to be accomplished for at least four to six weeks prior to considering XX XX. In this case, the patient has had only three sessions of physical therapy, possibly a short trial of XXXX (but certainly not four to six weeks), and no documentation of an ongoing home exercise program. Therefore, according to this criteria as well, the patient is not an appropriate either. Therefore, the requested XX XX and XX of the XX-XX XX XX XX is not medically reasonable or necessary, appropriate, or in accordance with the ODG guidelines 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 KNOWLEDGBASE**
- AHCPR- 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 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)