# Medical Assessments, Inc.

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**Amended April 22, 2019**
April 16, 2019

**IRO CASE #:** XX

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
Ultrasound guided XX injection XX XX

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
The Reviewer is a Board Certified Orthopedic Surgeon 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]:**

XX: UR performed by XX: Rationale for denial: Explanation of findings: No. The documentation available indicates that the injured worker previously underwent surgical intervention on the XX XX to include XX XX repair. Overall, there seems to be some pain with ROM but no evidence of weakness or positive impingement testing. It is unclear why a XX XX injection be required. Additionally, guided do not support ultrasound guidance. As such, the request is considered not medically necessary.

XX: UR performed by XX: Rationale for denial: The provider documentation reveals evidence of residual XX XX pain approximately XX months out from XX XX repair, XX decompression, XX and debridement. The clinician suggest that the lingering symptoms may be XX in nature and they have recommended a XX injection for diagnostic purposes. While there is no evidence of adhesive capsulitis, persistent impingement syndrome XX XX XX or XX given the clinical picture, performing a diagnostic injection is appropriate to determine if the residual pain is coming from the XX itself or if it is XX and major as this can help direct future treatment. In addition, if the residual pain is from the XX itself, the injection can reduce inflammation and potentially resolve the lingering pain. As such, deviation from the guidelines is warranted for the XX injection, however, ultrasound guidance is not typically necessary for XX injections and there is no rationale for why ultrasound guidance is needed. Based

on the provided documentation, the XX XX XX injection is necessary, but the ultrasound guidance is not medically necessary.

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

The request for ultrasound guided XX injection XX XX is denied.

This patient underwent XX XX XX XX repair XX months ago. XX continues to have pain in the XX. The treating physician is concerned that the XX pain may be XX in origin. XX has recommended an ultrasound-guided XX XX injection to determine the source of pain.

XX XX injections are typically performed in the office without ultrasound guidance. There are no unusual circumstances in this case that require ultrasound guidance for this injection.

The request for **Ultrasound guided XX injection XX XX** is found to be not medically necessary.

**ODG Guidelines?**

**Criteria for Steroid injections:**

*Lowest doses of XX should be used. Intra-articular XX and XX should be minimized or avoided (saline OK for dilution) due to additional XX*

XX

**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 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)**