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Date notice sent to all parties: 04/09/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX (XX) joint injection with sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

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

X 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 joint injection with sedation – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on XX when XX was involved in an XX. Earlier records document a XX XX injury. XX XX x-rays from the emergency room on XX revealed no

fracture or dislocation. No acute trauma was noted on XX films or a CT scan of the XX. A XX XX MRI revealed a disc XX at XX-XX and a XX disc XX that impinged upon the XX XX root sleeves at XX-XX. XX then underwent a XX XX-XX ESI on XX followed by XX-XX XX and XX on XX. The patient then started to treat at XX XX & XX XX as of XX. XX had undergone surgery on XX and woke up the XX XX after surgery with XX sided XX XX pain and radiculopathy symptoms and XX still had these symptoms. XX had XX XX pain that radiated to the XX XX extremity with tingling, numbness, and burning. XX range of motion was limited throughout and strength was 4/5. DTRs were 2+ throughout, but sensation was decreased on the XX at XX and XX. Faber's was positive on the XX. XX and XX were continued and XX was added. An MRI and a UDS were ordered. Another XX MRI was then obtained on XX that revealed a residual/recurrent XX posterior disc XX at XX-XX with potential contact of the transiting XX XX nerve. There was also potential contact of the exiting XX XX neve at the XX-XX level. A mild XX disc XX was also noted at XX-XX. The patient then followed-up on XX and the diagnosis was XX XX. XX was asked to return after a surgical consultation. XX saw the patient on XX and due to instability on XX flexion and extension views, recommended XX-XX fusion surgery. The patient then underwent XX-XX posterior interbody fusion, XX XX, complete XX, and complete XX on XX. XX evaluated the patient on XX and the risks of XX surgery given XX obesity was discussed. An external bone growth XX was recommended. On XX, the patient was doing well and asked to return in XX XX for a follow-up CT scan. XX x-rays on XX were reviewed, as well as therapy notes. A CT scan on XX revealed post surgical changes related to X, XX XX placement, XX, and posterior fixation at XX-XX. There was severe XX and moderate XX XX XX XX at XX-XX. The carrier provided an adverse determination letter on XX for the requested XX joint injection. XX. XX then examined the patient on XX for XX XX XX pain and numbness in the XX XX. XX. XX had recommended XX XX joint injections to rule out XX joints as the source of XX pain prior to proceeding with another XX surgery. XX joint injections were then recommended, which the carrier provided an adverse determination for on XX.

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

The patient was initially diagnosed as having XX XX at the XX-XX level and has failed to improve with XX and fusion performed by XX. XX, as noted above. Then, for XX ongoing symptoms, XX was treated with an interbody fusion by XX. XX and has failed to improve from that. Based on the documentation provided for review at this time, there is no objective evidence of any injury to the XX joint. The described pain complaints are consistent with failed XX surgery and radicular complaints, in my opinion. Furthermore, the ODG, at this time, does not recommend the use of XX injections. XX injections are indicated on a case-by-case basis for inflammatory types of XX, which is not present in this instance. It is specifically not indicated as a diagnostic test, as there is no further definitive treatment that can be recommended, according to the peer-reviewed medical literature. At this time, there is no indication for XX injection of any type. The requested XX joint injection with sedation is neither reasonable nor medically necessary and it is

not in accordance with the ODG. Therefore, 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 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**

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X 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)**