AccuReview

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[Date notice sent to all parties]: January 28, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX XX XX XX/XX, XX/XX on the XX CPT: 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 18 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: Office Visit dictated by XX. CC: Claimant stated XX and XX. Reported XX about XX from a XX on XX, no XX, XX hit XX XX side and twisted XX XX XX, XX re-injured XX on XX, has been seen in XX XX rooms. XX: XX XX: Appears with XX and XX. XX XX XX contusion/pain/XX. ROM limited in XX. XX over XX XX. Assessment: Contusion of XX XX XX, XX contusion, XX strain. Plan: Start XX, XX, PT referral for XX contusion, contusion of XX XX XX, XX strain., XX week for XX weeks, XX-XX XX, XX.

XX: Single View XX dictated by XX. Impression: No evidence of acute XX XX, communicable disease or XX.

XX: XX XX dictated by XX. Impression: Normal XX XX series.

XX: XX XX dictated by XX. Impression: Normal XX XX.

XX: Office Visit dictated by XX. CC: XX XX XX and XX and XX XX pain. XX: XX XX: appears with XX and XX and XX to XX

XX. ROM limited in XX. Assessment: contusion of XX will of XX, contusion of XX XX wall, XX strain. Plan: Start XX, XX.

XX: Office Visit dictated by XX. CC: XX. XX: functional restoration and status of healing. Healing is in the beginning stages. Assessment: XX XX, strain of XX region, subsequent encounter, contusion of XX XX XX. Plan: start XX, XX of XX XX and contents, XX w/o XX.

XX: Office Visit dictated by XX. CC: XX strain and XX XX. Claimant complained of pain that starts in XX XX XX and radiates to XX. Pain XX/10. Functional Restoration and Status of Healing: Claimant is approximately XX% of the way toward meeting the PDL. Assessment: XX XX, XX; XX strain; start XX, changed XX to scheduled doses and stopped XX and XX and XX.

XX: Office Visit dictated by XX. CC: XX XX XX pain radiating to XX XX. XX is currently working but stated that XX pain and disability is getting worse, XX is requesting refills on XX medication and has an XX scheduled. XX: XX and XX pain. XX: XX: XX XX and XX XX tenderness, pain radiates to the XX XX extremity, limited ROM, XX painful, XX painful, XX XX XX XX painful, XX XX XX XX painful. Assessment: Contusion of XX, contusion of XX XX XX, XX strain, XX XX, XX. Plan: Start XX and XX and XX, with referral to PT XX week x XX weeks.

XX: XX XX wo XX XX dictated by XX. Impression: Normal XX-XX XX of the XX XX.

XX: Office Visit dictated by XX. CC: f/u XX XX injury. XX intermittent XX/XX in XX XX XX extremity. XX: XX XX: Appears normal with XX present in XX XX and XX XX XX. Pain radiates to the XX XX extremity. Limited ROM, XX and XX painful, XX XX painful XX and XX XX XX painful. XX: intermittent numbness/tingling of the XX XX with normal XX. Roughly XX% of anticipated healing has taken place. Assessment: Contusion of XX, contusion of XX XX XX. XX strain, XX XX, XX. Plan: Start XX, advised claimant to keep scheduled appointments with XX; activity status: no work.

XX: Consultation dictated by XX. XX: Claimant XX on XX, went to the XX XX, XX, medications, seen at XX initially. On XX had XX, prescription XX and XX, XX, XX. XX had XX on XX, which was negative. Complaining of XX XX, radiating to the XX XX extremity. PMH: XX, XX, XX. Allergies: XX, XX, XX, XX, and "XX" medications. Medications: XX, XX. Surgeries: XX, XX XX XX XX repair. Social HX: denies XX, does XX, denies XX or XX XX. PE: XX and XX XX is poor on XX, XX positive on XX, decreased ROM in XX, XX and XX. XX also has pain in the XX, XX XX-XX, XX-XX XX. Assessment: XX sprain/strain. Claimant needs refill on XX, however due to negative XX hard to reconcile the need with the claimant's XX. XX has positive XX XX. Recommend XX XX XX on the XX XX-XX, XX-XX, and the other diagnostic test we might order is XX XX/XX. Follow up in XX weeks.

XX: Referral Prescription dictated by XX. Recommend Injection – XX. Referral Focus: Other- XX extremity, XX. DX: XX.XX XX, XX region, XX.XX strain of XX, XX and tendon of XX XX, subs, XX.XX Contusion of unspecified XX XX of XX, int XX.

XX: UR performed by XX. Reason for denial: The clinical basis for denying these services or treatment: Peer to peer was attempted but not established. ODG discusses criteria for the use of diagnostic XX for XX "mediated" pain require a clinical presentation consistent with XX XX pain. In this case, the requested procedure is not determined to be medically necessary as the documentation does not support a clinical presentation with clinical evidence consistent with potential XX-XX XX pain. Documentation does not support evidence of increased XX pain with XX and XX motion of the XX XX, nor demonstrates positive XX loading maneuvers with increased XX pain. Additionally, review of the supplied CPT codes is beyond the scope of utilization review and is defined to bill review with its knowledge of any/all applicable, jurisdictional XX codes, jurisdictional fee schedules and NCCI edits. Non-certification is recommended.

XX: UR performed by XX. Reason for denial: Regarding the requested XX XX injections, evidence-based guidelines indicate that these XX are selectively recommended for patients with XX mediated pain. There should be no evidence of XX pain, XX XX, or previous XX. Patients should also be involved in active therapy. In this case, the patient did report radiating characteristics of pain, as well as diminished motor strength and positive straight XX raise on examination. There was insufficient evidence to support XX mediated pain and therefore the necessity for XX XX. The request was previously denied for similar XX mediated pain and therefore the necessity for XX XX. The request was previously

denied for similar reasoning, and there was insufficient evidence to support overturning the previous denial. As such, XX XX block XX-XX, XX-XX on the XX with CPT codes XX, XX, XX, XX is non-certified.

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, this request is non-certified. ODG Guidelines indicate that these blocks are selectively recommended for patients with XX mediated pain. There should be no evidence of XX pain, XX XX, or previous fusion. Patients should also be involved in active therapy. In this case, the claimant did report radiating characteristics of pain, as well as diminished motor strength and positive straight XX raise on examination. There was insufficient evidence to support XX mediated pain and therefore necessity for XX XX. The request XX XX XX XX/XX, XX/XX on the XX CPT: XX, XX, XX, XX is not medically necessary and therefore denied.

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)**