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DATE: 12/30/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX XX Block XX, XXXX and XX XX Block XX

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

The reviewer is certified by The American Board of Anesthesiology with over 11 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]:

XXXX. XXXX initially presented with upper bilateral XX pain and pain on inhalation.

XXXX: Initial visit with XXXX. Pt presents with upper XX XX pain and pain while inhaling. C/O XX pain and stiffness, but no decreased flexion, extension, lateral bending, or rotation. No LE numbness, tingling or weakness. Pain does not radiate. Symptoms are constant and unchanged. No associated symptoms are reported. No exacerbating factors. No relieving factors are reported. On Physical Exam: XX XX- normal XX, no tenderness and Full ROM. XX XX- appearance is normal. No tenderness. Palpation reveals XX muscle spasms. Full ROM. Normal motor strength and motor tone. Assessment- XX to XX. Plan: Start XXXX, hot/cold pack, Point relief XX tube.

XXXX: XX XX X-Ray. Impression- Normal XX XX.

XXXX: Follow-Up with XXXX. Pain level XX/10. States XXXX has taken medication as directed and continues to have pain. Pt did not agree to PT initially but states XXXX will participate in PT if it will improve symptoms. Denies numbness, tingling, dizziness or difficulty walking. Pain is aching in nature. XX severity. Start XXXX and Physical Therapy XX times per week for XX weeks.

XXXX: Follow-Up with XXXX. Pt reports initially pain with XX pain, XXXX XX and mid XX. XX days later XXXX started having sharp, severe pain in the XX XX area and mid XX area. Pain has become worse. Pain with breathing. Reports the pain medication helps but makes XXXX dizzy. Physical Therapy is painful. XX XX on exam is tender at the XX-XX level XXXX paraspinal but not XXXX paraspinal, not in the XXXX or XXXX XX muscle. ROM is limited in all planes. Start XXXX. Administer XXXX.

XXXX: Follow-Up with XXXX. C/O severe pain in XX and pain in mid upper XX and XX with movement of XXXX head. XXXX reports XX when the pain is most severe. Reports XXXX helps with the pain. XX XX on exam shows tenderness in the XX XX XX, XX XX and XX XX muscle. XX muscle spasms. XX. Flexion, XXXX Side Bending, XXXX Rotation, Extension, XXXX side Bending and XXXX Rotation are ALL XX. XX XX tenderness XX and in the Ulevel XXXX XX. XX in all planes.

XXXX: Follow-Up with XXXX. Minimum change in symptoms. XXXX has started PT. Pain XX/10 upper/mid XX pain that is XX in nature. Only taking XXXX.

XXXX: MRI C-XX. Impression- 1. Straightening of the XX XX, suggestive muscle spasm. Multilevel XX neural foraminal XX, greatest on the XXXX at XX. 2. XX XX XX disc protrusion/XX at XX producing minimal XXXX ventral XX contouring and XXXX ventral XX nerve rootlet anatomic impingement. Advise clinical correlation for XXXX XX XX. 3. Central XX disc XX/herniation's at XX and at XX producing midline XX sac indentation without significant neural compromise at either level. 4. Central XX disc protrusion/XX at XX produces XX sac indentation without significant neural compromise. 5. XX and XX5 levels are free from disc protrusion or significant neural compromise.

XXXX: MRI T-XX. Impression- 1. XX arthropathy and XX flavum XX at XX produce XX XX sac indentation, minimal XXXX XX XX cord contouring and XX XX nerve rootlet anatomic XX XX. Less than XXmm annular bulge. 2.

XX arthropathy and XX flavum XX at XX produce XX XX sac indentation with possible XX intrathecal XX nerve rootlet anatomic impingement XX. No cord flattening. Less than XX mm annular XX. 3. Rightward XX-XX disc protrusion/XX at XX produces XX sac indentation without significant neural compromise. Less than XX mm XXXX XX disc protrusion/XX at XX produces XX sac indentation without significant XX compromise. 4 XX XX disc XX/herniation at XX produces slight midline XX sac indentation without significant neural compromise. Less than XX mm central disc XX/herniation at XX produces midline XX sac indentation without significant neural compromise. 5. Remaining XX intervertebral disc levels are intact. No vertebral body compression fracture or deformity or XX. No XX XX signal.

XXXX: Consultation with XXXX. Patient states XXXX pain is constant, it is mainly XX does not radiate. States XXXX also has XX knee pain. Working full duty at this time. States XXXX has been taking XXXX and physical therapy with no significant help. XXXX was given XXXX l as well. XXXX has been given XXXX n, which XXXX takes at bedtime. History of XX surgery in the past, fusion. Currently taking XXXX. Decreased Rom XX physical exam of the XX XX with flexion, extension and XX rotation. XXXX has tender XXXX XX, XX XX. XXXX has pain on XX rotation. XXXX has palpable tenderness at XX XX levels with XX spasms. XXXX has good toe and hell XX. Straight leg raise is XX XX. Assessment: XX and XX sprain. I would like to do XXXX XX, XX XX branch block with physical therapy to follow, XX XX XX block with physical therapy to follow. If these are successful, the patient will then get radiofrequency XX with physical therapy. I would also like the pt to be evaluated by an orthopedic surgeon because of the indentation on the XX cord and the XX XX.

XXXX. Rationale- ODG discusses indications for therapeutic XX injections of the XX or XX XX, noting "not recommended" but if it is done, then recommended at the most two levels but not more than two levels as recommended in this case. It is unclear if the claimant has localized XX mediated pain likely to benefit from these injections. Moreover, the current request is for intravenous sedation. The medical records clearly do not document extreme XX or another specific reason to support the indication for such sedation. Guidelines also recommend that there not be evidence of a competing diagnoses such as XX pain, XX XX or previous fusion.

XXXX: UR by XXXX. Rationale- Documentation does not substantiate objective findings consistent with XX mediated pain. There is no tenderness noted over the facets at the XX region. In addition, IV sedation is being requested, however, is not recommended for routine pain management procedures, especially XX branch blocks as it may skew the results. Overall, this request is not XX.

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

The previous adverse decisions are Upheld. Based on the records submitted and peer-reviewed guidelines, this request is non-certified. ODG discusses indications for therapeutic XX injections of the XX or XX XX, noting "not recommended" but if done, then recommended at most two levels but not more than two levels as recommended in this case. It is unclear if the claimant has localized XX mediated pain likely to benefit from these injections. Guidelines also recommend that there not be evidence of a competing diagnoses such as XX pain, XX XX or previous fusion. Therefore, the request for XX XX Block XX, XX, XXXX and XX Facet Block XX XX is considered not medically necessary.
PER ODG.

Recommend no more than one therapeutic intra-articular XX block when XX joint pain is suspected, but not XX blocks. Recommend no more than one set of XX branch diagnostic blocks prior to facet neurotomy, but not recommend medial branch blocks except as a diagnostic tool. Not recommend a multiple series of XX joint injections. Not recommend XX XX joint injections.

Not recommended.

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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 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)**