CASEREVIEW

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January 22, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Diagnostic XX XX injection at XX XX-XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Anesthesiologist with over 12 years of experience including Pain Management.

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]:
The claimant is a XX year old XX who was injured on XX when XX XX, twisting XX XX.

On XX, the claimant presented to XX with XX XX XX pain, not no lower extremity numbness or lower extremity tingling or weakness. XX pain was rated XX/10. On exam there was XX XX tenderness present at XX-XX. Palpation revealed XX XX XX. Limited ROM with pain. Straight Leg Raise and Waddell test were negative. X-rays were negative. Assessment: 1. XX sprain. 2. XX pain syndrome. Plan: Start XX XX mg and physical therapy XX. Work restrictions were provided.

On XX, the claimant presented to XX with improving symptoms. After XX sessions of PT XX reported doing 30% better. Plan: Continue with PT.

On XX, the claimant presented to XX with improving symptoms. After XX sessions of PT XX reported doing 50% better. XX rated XX current pain level XX/10. On exam there was XX XX tenderness present at XX-XX. Palpation revealed XX XX XX. Limited ROM with pain. Straight Leg Raise and Waddell test were negative. Plan: Continue with PT and restrictions.

On XX, the claimant presented to XX with continued XX XX pain rated XX/10. XX denied XX XX numbness, tingling or weakness. After XX sessions of PT XX reported doing 50% better. On exam there was XX XX tenderness present at XX-XX. Palpation revealed XX XX XX. Limited ROM with pain. Straight Leg Raise and Waddell test were negative. Plan: XX MRI for further evaluation due to lack of improvement with additional PT.

On XX, MRI XX XX Impression: 1. Normal XX body heights and alignment with XX XX and mild XX X at XX-XX. 2. At XX-XX, XX broad-based XX XX that does not contact XX structures with a XX XX XX XX/tear. There is mild XX XX XX. The XX XX and XX are patent. 3. No XX XX or XX XX.

On XX, the claimant presented to XX with continued mild symptoms. Plan: Referral for evaluation and treatment of XX XX.

On XX, the claimant present to XX for consultation of XX XX pain. On examination XX was positive on the XX. There was decreased sensitivity in XX XX on the XX. XX had decreased ROM in XX and XX of the XX XX. XX also had some tenderness XX at the XX-XX XX on the XX and XX XX area. Assessment: XX sprain/strain. Plan: Diagnostic XX-XX XX XX XX injection under XX with sedation.

On XX, XX performed a UR. Rationale for Denial: Per Official Disability Guidelines (ODG) regarding XX XX XX injection criteria, "XX." In this case, MRI did not reveal XX XX impingement. There is no record of an XX.

On XX, XX performed a UR. Rationale for Denial: The previous non-certification is supported. According to the guidelines, there must be evidence of radiculopathy on diagnostic imaging or testing to support the request. There was no evidence on diagnostic imaging of the XX XX of XX XX impingement or evidence on XX studies to confirm XX. There was also no documentation to support failure of a XX XX of care to include physical therapy to support the request.

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. Per ODG, there must be evidence of radiculopathy on diagnostic imaging or testing to support the request. There was no evidence on diagnostic imaging of the XX XX of XX XX impingement or evidence on XX studies to confirm XX. There was also no documentation to support failure of a XX XX of care to include physical therapy to support the request. Therefore, the request for diagnostic XX XX injection at XX XX-XX is not found to be medically necessary at this time.

PER ODG:

XX XX XX, diagnostic

Body system:
XX XX
Treatment type:
Diagnostic Testing, Injections

Conditionally Recommended CR

Recommended in selected cases as indicated below.

ODG Criteria

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)**