Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: JANUARY 9, 2019

IRO CASE #: XX

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

XX Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XX who was injured on XX, in a XX. The claimant was diagnosed with a XX and XX sprain. An MRI of the XX on XX, documented a broad-based XX and causing flattening of the XX. There was mild XX. An MRI on XX, documented an unremarkable XX. There was XX. XX. XX XX branch blocks and XX epidural steroid injections were recommended along with diagnostic epidural steroid injections at XX. On XX, there was pain of XX/10 on a Visual Analog Scale. There was radiation of pain into the XX extremities and XX pain with radiation into the XX extremity. There was decreased XX range of motion with tenderness in the XX area on the XX. XX pain was noted on rotation, extension, flexion, and to palpation. There was poor XX with XX straight leg raise testing XX. An evaluation on XX, documented pain of XX/10 on a Visual Analog Scale to XX/10 on a Visual Analog Scale. No significant changes were noted in the physical examination. The claimant was stated to possibly be a candidate for chronic pain management program if the injections are noncertified. Medications included XX, XX, XX, and XX.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM XX'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

XX facet injections are not recommended. There is no clear indication to support the necessity of XX facet injections in addition to epidural steroid injections. XX epidural steroid injections are not

recommended under the guidelines, nor are they recommended at the same time as facet injections. There was no clear documentation that the claimant would go onto radiofrequency XX or the facet injections were diagnostic. There was no evidence of radiculopathy on physical examination to support XX epidural steroid injections or XX epidural steroid injections including XX, XX, or XX. There was not electrodiagnostic testing or XX noted on imaging to support the requested injections. The medical necessity for XX, epidural steroid injection a t XX, and diagnostic epidural steroid injection at XX, has not been established. Therefore, the procedures are not certified.

REFERENCE:
XX

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX XX POLICIES OR GUIDELINES

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

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES