MEDRx

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DATE OF REVIEW: November 18, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

XX XX epidural steroid injection at XX-XX (XX) with sedation

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery

REVIEW OUTCOME

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

☒ Upheld (Agree)

☐ Overturned (Disagree)

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

The reviewer agrees with the previous adverse determination regarding the medical necessity of: lumbar interlaminar epidural steroid injection at XX (XX) with sedation

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a XXXX who sustained an XX injury on XXXX. Injury occurred when XXXX was XXXX with onset of XX XX pain. A review of records documented conservative treatment to include physical therapy, home exercise program, medications, activity modification, ice and heat.

The XXXX XX XX MRI impression documented an XX/XX small XX XX disc XX with minimal mass effect on the central XX XX XX XX.

The XXXX orthopedic report cited complaints of grade XX/10 XX XX pain. XXXX reported complaints of long-standing XX XX pain since XXXX. XXXX had completed XX sessions of physical therapy and a home exercise program with no improvement. XXXX felt like it had gotten worse over time. XXXX reported pain was grade XX/10, but with certain activities, such as prolonged sitting or walking, it could get up to more severe levels. Medications had included XXXX. XXXX reported that these medications had helped XXXX to XX, but did not control the pain. XXXX denied any neurologic complaints, such as XX, XX, or XX in XXXX XX XX. XX XX exam documented some XX XX XX XX, and no pain with XX XX compression. XX XX XX exam documented XX/XX strength, intact sensation, and XX+ and XX deep tendon reflexes. XX XX x-rays showed mild XX throughout the XX XX, including some early disc XX at XX/XX. There was no evidence of XX XX compromise and no evidence of instability on flexion and extension views. XXXX had an MRI but did not have the disc with XXXX today. The diagnosis was XX-XX due to XX XX disc XX. The patient had a little over XXXX months of XX XX pain without XX or signs of XX compromise. XXXX had undergone extensive physical therapy without any improvement at this point. It was not felt that any surgical intervention was indicated. The treatment plan recommended a trial of XX care, and referral to a pain management doctor for potential trigger point injections.

The XXXX pain management report indicated that the patient presented with a chief complaint of grade XX/10 XX pain. It was noted that XXXX had pain XX to the XX XX XX with associated XX over the XX of XXXX XX, XX greater than XX. XXXX had been prescribed a XX XX XX which did not help. Pain was affecting XXXX ability to perform activities of daily living. Heat/ice helped minimally. XXXX underwent chiropractic/physiotherapy without resolution of XXXX symptoms. Current medications included XXXX. XX XX exam documented XX XX pain, positive XX and equivocal XX straight leg raise, XX to palpation over the XX XX XX, and positive XX XX. XX XX neurologic exam documented XX/5 XX great XX XX, and mild decreased sensation over the XX XX XX. MRI showed an XX/XX XX XX broad-based disc XX with XX XX of XX. The diagnosis included XX XX, XX XX, XX XX, and chronic pain syndrome. Clinical exam findings were consistent with XX XX to the XX XX XX in an XX distribution. A diagnostic epidural steroid injection was recommended to evaluation the cause of XX pain as it was consistent with an XX XX. It was noted that clinical findings were consistent with XX but imaging findings were inconclusive. The treatment plan recommended XX support; begin XX, and diagnostic XX epidural steroid injection XX/XX.

The XXXX peer review report denied the request for XX XX epidural steroid injection at XX/XX with sedation. The rationale stated that there was no clear evidence that the patient was not responsive to muscle relaxants and XX drugs before consideration of an epidural injection, and no documentation of XX to support the sedation with the XX epidural steroid injection for this patient.

The XXXX orthopedic report indicated that the patient presented with complaints of grade XX/10 XX XX pain without XX symptoms. XXXX pain was not improved despite XX medication and physical therapy. XXXX saw the pain management specialist who had recommended an epidural steroid injection to target the XX/XX disc. XX extremity XX exam documented XX/5 strength, intact sensation, and XX/XX XX and XX reflexes XX. XXXX had some tenderness in the XX XX in the XX XX XX. MRI was available for review and showed

some evidence of early disc XX at XX/XX with a small disc XX in the XX XX aspect of the XX/XX disc with very mild displacement of the XX **XX** XX XX. The diagnosis included XX XX XX. Imaging was reviewed with the patient. It was discussed that given XXXX symptoms of XX XX pain and in the absence of XX type pain in the XX or other symptoms of XX XX, there was no indication for surgical intervention. It was noted that XXXX could return to work without formal restrictions. XXXX was advised to use over-the-counter medications for pain control while at work.

The XXXX pain management pre-authorization request indicated that the patient had clinical findings consistent with XX XX to the XX XX XX in an XX distribution. A diagnostic epidural steroid injection was recommended to evaluate the cause of XX pain as it was consistent with an XX XX. The goal was to reduce pain and inflammation in order to maximize participation and improvement in remainder of physical therapy sessions.

The XXXX peer review report denied the appeal request for XX XX epidural steroid injection at XX/XX with sedation. The rationale stated that guidelines require a failure of previous conservative treatment prior to initiation of epidural steroid injection to include the use of XX XX and XX medications. It was noted that the patient had just been initiated on a trial of XXXX without time or documentation of effect provided to be considered a failure of a trial. Additionally, guidelines do not support the use of sedation associated with the requested injection.

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

The prospective request for XX XX epidural steroid injection at XX-XX (XX) with sedation is not medically necessary. The denial is upheld.

XX.

XX.

This patient presents with a primary complaint of XX XX pain with records indicating that XXXX currently does not have any XX symptoms or signs of XX compression. The orthopedic surgeon did not document any signs of XX compression. The pain management physician has documented findings reportedly consistent with an XX XX. There is imaging evidence of an XX/XX small XX XX disc XX with minimal mass effect on the XX XX XX XX XX. Guideline criteria have not been met for a diagnostic epidural steroid injection as there is no evidence that imaging is inconclusive or ambiguous, or that there is evidence of multilevel nerve root compression, or that the patient had a previous XX surgery. Additionally, guideline criteria have not been met for a therapeutic epidural steroid injection as there is no clear documentation of XX on current orthopedic exam, or that the patient has been unresponsive to optimized conservative treatment, including neuropathic drugs as XXXX has just been prescribed. Therefore, in this reviewer's opinion, the request for XX XX epidural steroid injection at the XX/XX level (XX) with sedation is not medically necessary.

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**
ODG Treatment
Integrated Treatment/Disability Duration Guidelines
Updated

☐ **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)**