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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX epidural steroid injection (ESI) with monitored anesthesia.

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

REVIEW OUTCOME:

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

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

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]:

On XXXX, the patient underwent an evaluation by XXXX. The diagnosis was XX of muscle, XX and XX of XX XX. XXXX assessed the patient was at clinical maximum medical improvement (MMI) on XXXX. It was deemed the patient did not have any permanent impairment as a result of the XX injury. The treatment plan included medication management with XXXX and physical therapy (PT). The patient was released from care and placed on regular duty.

On XXXX, a magnetic resonance imaging (MRI) of the XXXX knee was performed at XXXX. The study showed mild XX XX XX XX or less likely horizontal closed XX involving the XX XX body aspects of the XX XX.

On XXXX, an MRI of the XX XX performed at XXXX, interpreted by XXXX. The study showed XX XX XX measuring approximately XX mm at XX minimally contacting the XX XX without stenosis.

On XXXX, the patient was seen by XXXX, for XX XX and XXXX knee pain. The XX XX pain was rated XX/10. The pain was located in the XXXX XX XX. The pain radiated to the XXXX XX and XXXX thigh. The pain was XX and XX. The associated symptoms included XX XX,

decreased XX and XX XX XX. The exacerbating factors included twisting, walking, lifting and bending. The pain was better with XX. On exam, there was XX over the XXXX XX at XX. There were XXXX-sided muscle XX on XX. The flexion was XX degrees, extension XX degrees, XXXX XX side bending XX degrees, XXXX XX rotation XX degrees and XXXX XX rotation XX degrees with pain. There was XX and XX in the XX aspect of the XX. The straight leg raise (SLR) was XX. The diagnosis was XX of the XX region. The treatment recommendations included medication management with XX and referral to Pain Management. The patient was placed on light duty.

On XXXX, the patient was seen by XXXX, for XX XX pain. XXXX had persistent XX XX pain. The pain was in the XX XX XX region. The pain was XX. It was worse with standing, walking, XX extension, getting up from sitting position, twisting, activity, lifting, riding in a car, driving and pulling. The XX XX XX pain was noted in the XX distribution. The pain was worse by XX flexion, extension and activity and better in a XX position. It was noted that the patient failed to get relief with PT and medications. On exam, the patient's gait was XX, XX and XX. The seated SLR was XX XX for XX pain and radiating XXXX XX pain. The ROM was limited more in flexion than extension. The point of maximum tenderness was over the XX XX XX XX region. The diagnoses were XX XX with XX, XX disc XX with XX XX at XX, XX XX, XX strain/sprain. The patient had pain with sitting, standing, and walking, XXXX was having problems XX. It would hurt with XX and XX and XXXX had shooting pain radiating down XX XX distributions, and positive XX XX. The patient had XX XX since XX. The treatment recommendation was XX selective nerve root block/XX ESI at XX, PT and continuing the current medications.

On **XXXX**, Notification of Adverse Determination by **XXXX**, indicated the request for XX XX and XX XX epidural steroid injection with XX interpretation or fluoroscopy under monitored anesthesia care was denied on the basis of the following rationale: "*Per evidence-based guidelines, epidural steroid injection is recommended as a possible option for short-term treatment of XX pain (defined as pain in XX distribution with corroborative findings of XX) with use in conjunction with active rehab efforts. Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. In this case, the patient reported of XX pain, located in the XX lower XX XX region. XXXX rated the pain XX/10 on average, XX/10 at worst, XX/10 at least; XX/10 presently. The range of motion (ROM) was limited on flexion more than extension. There was normal sensory to light touch in the XX XX. Motor testing showed well developed and XX XX in the XX XX XX. No evidence of any weakness XX. No atrophy or fasciculations were noted. Tone normal. Heel walking was normal. Toe walking was normal. Deep tendon reflexes in the patellar was XX+/5 XX, and Achilles was XX/5 bilaterally. However, there were no imaging studies submitted for review to corroborate findings. In addition, there were limited objective findings on examination to suggest XX. Moreover, there was limited documentation of trial and failure of conservative treatments to warrant the current request.*"

Per Notification of Reconsideration Adverse Determination by **XXXX**, the request for XX XX XX epidural steroid injection with XX interpretation or fluoroscopy under monitored anesthesia care was not certified on the basis of the following rationale: "*The current request is for XX XX Transforaminal Epidural Steroid Injection with Epidurogram Interpretation or Fluoroscopy under Monitored Anesthesia XX, XX x2, XX or XX, XX. Per guidelines, epidural steroid injection*

(ESI) is recommended to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, the reduction of medication use and the avoidance of surgery, but this treatment alone offers no significant long-term functional benefit. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Still, there were no imaging studies submitted for review to corroborate findings. There was still no clear evidence if the patient had failed from lower levels of care such as exercises, physical methods, NSAIDs, muscle relaxants, and XX drugs prior to considering the injection as there were no thorough physical methods and medication response. Also, there was still limited subjective complaints and significant objective findings to warrant the need for the request. Clarification is needed regarding the request and how it would affect the patient's clinical outcomes. Exceptional factors were not noted."

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

Indications of ESI
XX
Per the notes, the patient has XX symptoms without a specifically identifiable XX XX level etiology. After review of the available notes, the patient has a XX XX, XX, more predominant on the XXXX. MRI reviewed reveals disc XX at XX without neural XX. Therefore, the patient has XX signs in a nonspecific XX. The patient has been treated with medication (including XX and XX XX), PT, and rest. Therefore, the patient meets the criteria for a diagnostic epidural steroid injection.

Indications for diagnostic epidural steroid injection

1. To determine the level of XX pain, in cases where diagnostic imaging is ambiguous, including the examples below:
2. To help to evaluate XX pain generator when physical signs and symptoms differ from that found on imaging studies
3. To help determine pain generators when there is evidence of multi-level nerve root compression
4. To help determine pain generators when clinical findings are consistent with XX (e.g. dermatomal distribution) but imaging studies are inconclusive
5. To help to identify the origin of pain in patients who have had previous spinal surgery

In order to meet the criteria for #1, a 2 level XX epidural steroid injection (XX) is not Medically Necessary or reasonable. A single level (XX) is reasonable and Medically Necessary at this time. Per the MRI, there is clearly no involvement affecting the XX XX XX XX, whereas the XX XX XX may be affected by the XX XX XX due to an XX component. Therefore, a diagnostic XX XX XX with MAC sedation due to XX is certified as Medically Necessary.

X Medically Necessary

☐ Not Medically Necessary

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER

CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES