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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Diagnostic XX Epidural Steroid Injection XX on XXXX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Board Certified in Orthopedic Surgery

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 provider is requesting XXXX XX ESI.

XXXX – Physician Notes-XXXX: Reason for appointment: 1) Pt is here for XX month f/up and oral medication refill. 2) Post-XX XX. 3) XX XX pain. Today the patient reports that the pain is XX/10 in severity with the current medication regimen. The pain is currently located in the XX XX. The pain that is worse is in the XX. It is described as XX and has affected the patient's XX, XX, XX, and XX exercise. The pain is better with XX and worse with standing or sitting for long periods of time. The patient currently done physician directed home exercise. There has been no change in the patient's general health since last visit. Assessment: 1) XX XX pain XX (Primary); 2) XX XX syndrome XX) XX joint pain XX 4) Post-XX syndrome XX; 5) Muscular XX XX. Patient is present today c/o XX XX pain due to post-XX and chronic XX XX. Patient has a history of a XX XX in the XX region and XX additional XX after that. Treatment: 1) XX XX syndrome: Refill XXXX, XX tablet as needed every 8 hours. Notes: Comprehensive pain management plan: Pt has symptoms that maybe caused by failure of instrumentation, continued XX XX, and XX XX. Would benefit from MRI of XX XX with and without contrast. Last MRI over **XXXX**. Follow up in XX month.

XXXX – Radiology Report- **XXXX**: MRI XX XX with and without contrast. Clinical History: **XXXX** with chronic non-resolving XX pain and prior XX. Impression: 1) Demonstration of the known prior XX at XX through XX which appears intact and unremarkable without evidence of XX failure or some XX. 2) XXmm XX XX at XX minimally XX the XX XX without XX. 3) Minimal XX of the XX XX within the XX sac is identified at XX possibly representing XX. There is no significant enhancement of the XX roots.

XXXX – URA Determination- **XXXX**: This is a notice of adverse determination WC/WC Network. XXXX is certified by TDI to perform XX Utilization Review. The use of the word you within this documentation shall mean the injured employee, employee rep, or the employee's providers. XXXX has been asked to review the treatment request listed below for medical necessity and appropriateness. After care review of the submitted medical information, our Physician Advisor made the following determination: Diagnosis/Description: XX-Post-XX syndrome, not elsewhere classified, XX-XX XX pain, XX-XX XX syndrome, XX-XX disorders, not elsewhere classified, XX-Other symptoms and signs involving the XX system. Date of Physician Determination: **XXXX**. Treatment Requested: XXXX SI joint injection. List of medical records reviewed: 1) MD note XXXX; 2) MD note **XXXX**; 3) Request for authorization-MD note **XXXX**. Clinical Summary: **XXXX**. Most recently, XXXX was seen by **XXXX**. XXXX has pain XX/10 to XXXX XX XX and XXXX leg. The pain is XX in the leg. Per examination, XXXX is XX to palpation over the XXXX XX joint, there are XX XX and FABER and Patrick's tests are XX. XX ROM is limited due to pain, strength is XX XX and sensory examination is normal to XX XX XX. The current request is for a XXXX XX joint injection: Decision: Non-certified. Clinical Rationale: Regarding the request for the XXXX XX joint injection, ODG notes XX joint injections are not recommended for non-inflammatory XX pathology, which has not been documented in this case. Per the **XXXX** visit, this claimant has positive XX and XXXX is XX to palpation over the XXXX XX joint. There is an absence of documentation noting this claimant has XX. Therefore, this request is not supported.

XXXX – Physician Notes-XXXX: Reason for Appointment: 1) 2 month f/u; 2) XX pain; 3) Post-XX syndrome; 4) XX; 5) XX. Purpose of today's visit: Medication refill and discuss plan of care. Today, the pt reports that the pain is XX/10 in severity with the current medication regimen. The pain is currently located in the XX XX. The pain is worse in the XXXX leg. It is described as XX. The pain is better with XX XX and worse with standing or sitting for long periods of time. The patient has currently done physician directed home exercise. There has been no change in the patient's general health since last visit. (Incomplete Notes)

XXXX – Physician Notes-XXXX: Chief Complaint: The pt complains of XX XX pain. The pain radiates into the XXXX XX XX. Present Illness: Able to stand for less than XX minutes. Able to sit for more than XX minutes. Able to walk for less than XX minutes. Pain level now XX/10. Pain level at worst XX/10; pain level at best XX/10. The pain feels like XX. The pain feels better with XX. The pain has been going on for XX XX. The pain onset was associated with a XX XX-related injury in XXXX. The pain described as XX. XXXX has had multiple PT sessions with minimal or no help. Medication: trigger point injections. Assessment: Diagnosis: XX XX pain XX; XX XX syndrome XX. Plan: Other Treatment: Per ODG guidelines, diagnostic ESI is requested. Criteria for neurological deficits, imaging consistency and clinical findings are met. XX level on the XXXX. May be a candidate for XX XX XX. Follow up at this clinic as needed

for the procedure.

XXXX – URA Determination- **XXXX**: This correspondence serves as notification that the requested medical treatment –XXXX XX XX epidural steroid injection under anesthesia between **XXXX** – does not meet established criteria for medical necessity, based on our physician review of the information submitted. The following details provide specific information about the determination: Determination Date: **XXXX**. UR Determination: Recommend prospective request for XXXX XX XX epidural steroid injection under anesthesia between **XXXX** be non-certified. Principal Reason/Clinical Basis: **XXXX**. The provider is requesting certification for XX XX epidural steroid injection under anesthesia. Per the **XXXX** progress report, submitted by **XXXX**, the claimant presented with complaints of XX XX pain with radiation to the XXXX XX XX. The claimant noted that XXXX was able to stand for less than XX minutes, sit for more than XX minutes, and walk for less than XX minutes. XXXX rated XXXX pain XX/10, described it as XX of the XXXX XX XX. Upon examination, the provider noted XX heal and toe walking, XX deep tendon reflexes, a XX straight leg raise, and sensory deficit in the XXXX XX dermatome. The claimant had attempted PT with minimal or no help and trigger point injections. XXXX was not working. The provider noted that the claimant had a degree of XX; therefore, XXXX recommended MAC anesthesia. An MRI of the XX XX, performed on **XXXX**, revealed a prior XX at XX through XX without evidence of XX failure or XX, a XXmm disc XX at XX, and minimal clumping of the nerve roots within the XX sac at XX. A prior request for XX XX epidural steroid injection was non-certified. This non-certification was based upon the failure of documentation to reveal the planned injection level and the absence of clear documentation of neurological compromise in a XX fashion. The requested epidural steroid injection is not appropriate. Guidelines only support epidural steroid injections when XX due to XX nucleus XX is corroborated by exam and imaging findings and other treatment has failed. Although the claimant presented with complaints of XX XX and XXXX XX XX pain which was associated with diminished reflexes, sensory deficits, and a XX straight leg raise, imaging revealed a prior XX at XX through XX without evidence of fusion failure or XX. In the absence of imaging evidence suggestive of XX due to XX XX XX at XX, the requested epidural steroid injection is not appropriate. Therefore, the request for XXXX XX XX epidural steroid injection under anesthesia is non-certified.

XXXX – URA Re-Determination- XXXX: As a result of your request for a reconsideration of a previous non-certification, a physician reviewer who was not involved in the original determination has reviewed the request. This correspondence serves as notification that the requested medical treatment listed below does not meet established criteria for medical necessity, based on our second physician's reconsideration review of the information submitted. The original determination is therefore upheld. The following details provide specific information about the determination: Specific Treatment Plan Requested: XXXX XX XX epidural steroid injection under anesthesia between **XXXX**. This is an appeal to review this reconsideration. Determination Date: **XXXX**. UR Determination: Recommend prospective request for XXXX XX XX epidural steroid injection under anesthesia between **XXXX** be non-certified. Specific Clinical Reason for the Resolution/Clinical Basis for Decision: The claimant is a **XXXX**. Under consideration is the request for XXXX XX XX epidural steroid injection under anesthesia. This is an appeal to review **XXXX** 7. A prior request for XXXX XX XX ESI under anesthesia was non-certified in review XXXX by **XXXX**. The rationale behind the prior non-certification was

based on the lack of imaging evidence for XX XX XX at the requested segment. The provider has failed to submit any written basis for appeal nor has any new clinical information been submitted for consideration. Per the **XXXX** report, the claimant was being treated for XX XX with XXXX XX XX XX pain. The pain was graded XX/10 visual analog scale. XXXX was not working and had undergone prior PT without benefit. XXXX history was significant for prior XX surgery. Physical examination noted a XX XX for heel and toe walking with XX straight leg raise testing, sensory deficit and decreased reflexes. A **XXXX** MRI visualized a prior XX at XX through XX that was apparently intact and unremarkable without evidence of fusion failure or stenosis; a XXmm XX XX at XX with minimal indentation of the XX sac without stenosis; minimal clumping of XX XX with XX XX identified at XX possibly representing XX; but no significant enhancement of XX XX. The provider is appealing the prior determination at this time. The prior determination was appropriate. It is unclear if the claimant had undergone any prior steroid injections. There was positive provocative symptoms and decreased sensation on examination. However, there were no imaging or electrodiagnostic findings to conclusively demonstrate a XX at the requested level. Furthermore, the relevant imaging revealed a prior XX at XX through XX without evidence of XX failure or XX. Injection is therefore inconsistent with the cited guideline recommendations. Therefore, the request for XXXX XX ESI under anesthesia is non-certified.

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

The request for a XXXX XX epidural steroid injection (ESI) is denied.

This patient injured XXXX XX XX in **XXXX**. XXXX underwent XX XX XX XX. XXXX now has pain in the XX XX and XXXX leg. The **XXXX** MRI of the XX XX demonstrated an intact XX XX. XXXX has a XX mm disc XX at XX, which is not associated with XX. The treating physician has recommended a XXXX XX ESI.

The Official Disability Guidelines (ODG) supports ESI in patients with XX associated with a XX nucleus XX. Objective findings should correlate with imaging studies and/or electrodiagnostic testing.

The recent XX MRI study demonstrates no evidence of XX XX XX associated with a XX XX XX at XX. The requested injection is not medically necessary for this patient.

ODG Criteria
XX

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)**