# Medical Assessments, Inc.

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**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

XX Epidural Steroid Injection blockade with fluoroscopy at XX with IV Sedation

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

The Reviewer is Board Certified in the area of Anesthesiology with over 10 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]:**

**XXXX.**

XXXX: MRI XXXX XX interpreted by XXXX. Impression: XX% thickness partial XX of the XX and XX XX. There are no full thickness XX XX XX XX. XX XX joint XX and sub XX/sub XX XX. Mild XX joint capsule XX is appreciated, which could act as a source for rotator cuff XX.

XXXX: MRI XX XX interpreted by XXXX. No MR evidence of XX fracture or XX. XX, XX, and XX; normal. X: Broad XXmm disc XX XX. XX Broad XXmm disc XX with mild XX sac XX and mild XX XX XX narrowing.

XXXX: Initial evaluation by XXXX. Claimant reported pain in XXXX XXXX XX XX/10 it

does keep XXXX XX and XXXX has difficulty lifting XXXX hand over XXXX XX. XXXX has XX back from XX/10. XXXX has undergone PT and numerous medical management.

XXXX: Follow up note by XXXX. Claimant reported severe XX, XX and XX pain in XXXX arm associated with XX XX. XXXX has failed conservative rehab care. XXXX often has XX in the XX distribution. Received XX epidural blockade. Continued ROM and pt modalities.

XXXX: Follow up note by XXXX. Claimant reported continued XX to XX XX pain radiating to the XXXX XX, XX XX area associated with a continued feel like XX in XXXX XX, pain which is XX. XXXX has pain with XX. XX maneuvers are moderately XX. XXXX has already exhausted XX intervention in XXXX XX, it is XXXX XX and XX pain which is requiring treatment.

XXXX: Operative report by XXXX. Postoperative diagnosis: XX XX pain, chronic XX pain syndrome with XX disk XX at XX and XXXX XX XX.

XXXX: Follow up note by XXXX. Claimant reported more than XX% or XX% improvement of XXXX XX, XX and leg pain complaints following XX, arm and XX complaints following XX epidural blockade for persistent XX, XX pain following a XX injury. XXXX is regretting that why this was done this sooner. XXXX has cut XXXX now down to just XXXX showing good ROM. XXXX has decreased XX strength on the XXXX.

XXXX: UR performed by XXXX. Rationale for denial: XXXX. XXXX complains of XX and XXXX XX pain. XXXX had conservative treatment. The request is not medically necessary.

XXXX: Follow up note by XXXX. Claimant reported the first block over XX weeks ago offered XXXX excellent relief of pain, improved function and decreased us of medications. XXXX is XX XXXX off of XXXX down to XX dosing. However, XXXX XX pain continues associated with decreased XX ROM. XXXX wants to get back to XXXX former levels of activity at work. XXXX is citing XX over this denial as well as the procedure itself.

XXXX: UR performed by XXXX. Rationale for denial: The injured worker has ongoing complaints of XX pain. There was improvement of XX and XXXX XX pain at least XX% following XX ESI on XXXX. The request is not medically necessary.

XXXX: Follow up note by XXXX. Claimant had XX to XX XX pain associated with XX ROM. We have recommended second ESI to build upon the benefits from the first injection. XXXX is still having XX pain into the XX. XXXX is reporting more than XX% pain relief, improved function and decreased medicines. XXXX is using XXXX as well as an XX support. XXXX does not want XX XX and XXXX has done quite well.

**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. The injured XX has ongoing complaints of XX pain. There was improvement of XX and XXXX XX

pain at least XX% following XX ESI on XXXX. However, per guidelines, XX XX are largely experimental and not recommended. The request for XX Epidural Steroid Injection blockade with fluoroscopy at XX with IV Sedation is found to be not medically necessary.

**ODG Guidelines:**

**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)**