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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left Lumbar Transforaminal epidural steroid injection (TFESI) L4-5, L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Pain Medicine, Physical Medicine & Rehab

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a XXXX with history of an occupational claim. The mechanism of injury was not detailed in the documentation provided for review. The current diagnoses as radiculopathy of the lumbosacral region, chronic pain syndrome, spinal stenosis of lumbar sacral region, intervertebral disc disorder with radiculopathy of the lumbar sacral region, other intervertebral disc displacement of the lumbosacral region, other spondylosis with radiculopathy of the lumbosacral region and dietary counseling and surveillance. The MRI of the lumbar spine from XXXX revealed degenerative spondylosis without significant canal or foraminal stenosis. There was no evidence of neural compression or displacement. There was annular fissures at the L3-L4 and L4-L5. The progress note from XXXX notes that the patient was seen for complaints of lumbar spine pain. Pain was described as sharp and shooting as well as throbbing and was worse with standing it radiated down both legs. The patient had complaints of right shoulder pain and low back pain that radiated to bilateral legs worsening symptoms of the left leg. Pain was a 10/10. On examination facet loading test was positive on the right and left. Straight leg raise was positive on the left. There was tenderness palpation to lumbar spine as well as decreased painful range of motion. There was paresthesia to the left lower extremity in the position of the L4 and L5 nerve roots. There was diminished deep tendon reflexes to left lower extremity. The last epidural steroid injection helped more than 8 weeks and improved function was able to perform all activities of daily living without increased pain the patient stated XXXX had pain well-controlled medications for more than 8 weeks of the left injection.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The Official Disability Guidelines note that epidural steroid injections are recommended for patients with findings of radiculopathy on examination that is corroborated by imaging studies. Repeat injections

are recommended if there is evidence of 50-70% pain relief for 6-8 weeks. The documentation indicates that the patient had a decrease in pain for 8 weeks following the previous injection. However, the patient's specific objective functional improvement as well as decrease in pain by 50-70% was not indicated in the documentation provided for review.

Therefore, the request for Left Lumbar Transforaminal epidural steroid injection (TFESI) L4-5, L5-S1 is not medically necessary and the prior determination is upheld.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Low back, Epidural steroid injections (ESIs), therapeutic