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Date: 5/29/2018 8:19:07 AM CST

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L5-S1 transforaminal epidural steroid injection

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

REVIEW OUTCOME:

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

- | | |
|-----------------------------------------------|--------------------------------|
| <input type="checkbox"/> Overturned | Disagree |
| <input type="checkbox"/> Partially Overturned | Agree in part/Disagree in part |
| <input checked="" type="checkbox"/> Upheld | Agree |

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a now XXXX with a history of an occupational claim from XXXX. The mechanism of injury is detailed as a XXXX. The current diagnosis is documented as other intervertebral disc displacement to the lumbar region. Past treatment included medications, epidural steroid injection, TENS unit, massage, and physical therapy. On XXXX, it was documented this patient had complaints of pain to the low back that radiated to the right lower extremity. XXXX rated XXXX pain as 4-5/10. The patient reported 30% pain relief from the prior epidural steroid injection and XXXX numbness subsided. Upon physical examination, it was noted XXXX had tenderness to palpation to the lumbar spine with full range of motion. Straight leg raise was positive and motor strength was reduced.

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

According to the Official Disability Guidelines, repeat epidural steroid injections are given based on documentation noting at least 50% pain relief, decreased need for pain medications for six to eight weeks, and functional improvement from the previous injection. The clinical documentation submitted for review indicated this patient had evidence of radiculopathy on physical examination and 30% pain relief from the prior injection. However, there was no documentation noting objective functional improvement nor decreased need in medication use from the injection.

Consequently, the request is not medically necessary. As such, the prior denial is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Low Back (updated 05/04/2018), Epidural steroid injections (ESIs), therapeutic.