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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX selective XX / XX epidural XX XX XX XX XX, XX, and XX with XX interpretation of XX

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:

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

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX is a XXXX who sustained a work-related injury on XXXX. XXXX reported that XXXX. The ongoing diagnoses included status post XX XX-XX, marked XX XX XX at XX XX-XX and XX-XX; XX XX XX with XX / XX, marked at XX-XX, and moderate at XX-XX; XX XX XX XX at XX-XX and XX-XX; XX disease at multiple levels; acquired XX, XX XX grade I XX and XX-XX grade I XX; and mechanical XX XX pain, rule out XX versus XX. XXXX for a follow-up of XX XX pain and XX XX pain. XXXX also complained of XX XX XX pain XX on the XX, and XX noted in the XX XX, XX XX region, and XX XX. The pain was rated XX-XX/10. The symptoms were unchanged since the prior visit. The associated symptoms included XX XX, XX. On examination, XXXX presented in a XX. XXXX was in moderate XX. XXXX transferred with difficulty from the XX to the XX XX. There was XX XX pedal XX and 2+ XX XX XX. There was XX XX sensation (XX) in a XX-like distribution XX up to the XX. The XX XX XX showed XX XX/5 strength with normal tone, except X-/5 over the XX XX XX (XX) and XX-/5 over the XX (XX). A XX XX XX single scan dated XXXX, showed XX XX changes at the XX XX XX. Mild-to-moderate XX was noted at the XX XX. There was moderate XX at the XX and XX XX-XX XX XX, with adjacent XX XX XX attributed to reactive XX change. Mild-to-moderate XX was noted at the XX XX-XX XX, and mild XX was demonstrated at the XX XX-XX XX. Additionally, XX and a XX were observed. An XX of the XX XX was performed on XXXX. The study revealed XX XX XX with XX greatest at XX-XX, where there was mild-to-moderate XX XX XX and XX XX of the XX XX recess. The treatment to date included medications (XXXX), activity modifications (provided moderate relief), rest, ice, restriction, XX therapy, XX

unit, XX blocks, XX XX-XX XX XX, XX point XX, and surgical interventions including XX XX XX-XX, XX XX XX XX-XX, and XX XX XX repair. Per a utilization review letter dated XXXX, the requested services were denied by XXXX with the following rationale: "Based on review of the medical records provided, the proposed treatment consisting of XX selective XX XX block / XX epidural XX XX XX XX-XX and XX with XX, interpretation or XX is not appropriate and medically necessary for this diagnosis and clinical findings. XX. This claimant's injury was more than XXXX with prior XX / XX XX. It is unclear if there is a recent XX of the chronic pain state that would warrant a XX nerve XX XX. It is also unclear what the results of the recent XX scan was, and if further surgery is warranted. XX. Therefore, per ODG, the proposed treatment consisting of XX XX XX XX block / XX epidural XX XX XX XX, XX and XX with XX interpretation or XX is not appropriate and medically necessary for this diagnosis and clinical findings. Per a utilization review letter dated XXXX, a reconsideration request was received on XXXX. The prior denial was upheld by XXXX. XXXX documented that the requested services were not medically necessary for the diagnosis and clinical findings. Guidelines recommended no more than two XX root levels with XX approach. No exceptional circumstances were noted at XX levels. Therefore, the request was not medically necessary and the decision is upheld.

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

Based on the clinical information provided, the request for XX selective XX XX block / XX epidural XX XX, XX XX, XX, and XX with XX interpretation of XX, XX- XX(s), XX agent and/or XX, XX epidural, with imaging guidance (XX or CT), XX - XX(s), XX and/or XX, XX epidural, with imaging guidance (XX or XX), XX - XX Procedures of the XX and XX, XX is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certification is upheld. Peer review dated XXXX indicates that there is no indication for any further treatment related to the work injury. The patient will not likely improve any further with additional treatment including XX therapy, XX, XX, surgery, pain management, XX or referrals to specialists. XXXX is not a good candidate for any XX or any type of interventional procedures. It is unclear what significant benefit is expected for this patient who presents XX to a XX.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the decision 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