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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX

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]:
XXXX who reported an injury on XXXX. XXXX. XXXX suffered from XX and XX XX pain, XXXX. XXXX was diagnosed with XX with XX level, XX strain, XX pain. XXXX for XX pain. The pain had begun after repetitive episodes XX at work. The XX pain had started on or XX prior. The XX pain was located in the XX and XX XX. XXXX described XX pain as XX. It was present constantly and was varying in intensity. It was made worse by lifting, walking, and pulling and better by sitting, rest, heat application, medications, and lying on the side. The XX extremity symptoms began on or about XX months prior. The XX extremity pain was noted in the XX region and XX XX, which was XX. It was present intermittently and was varying in intensity. The symptoms were made worse by walking and better by rest, heat, and medications. The associated symptoms were XX, XX, and XX. The pain was rated at XX/10. On examination, XXXX was in distress and XX. Examination showed an XX XX and XX sensation (XX) in the XX area into the XX XX area and down to the XX XX region, at XX XX or XX of the XX, and into the XX or XX and XX of the XX. Straight XX raise testing while seated was XX XX for XX XX pain and XX pain. On XXXX, symptoms and examination findings were unchanged. An XX of the XX dated XXXX showed a large XX XX (XX XX) at XX, causing severe XX and XX XX. There was a XX at XX causing XX XX. Office visit note dated XXXX indicates that the patient complains of XX pain and XX XX pain. Pain level is rated as XX/10. Current medications are XXXX. The treatment to date included XX weeks of conservative care including medications, activity modification, XX therapy, and exercises without relief, as well as massage and XX unit

with improvement in symptoms. Per a utilization review decision letter and peer review dated XXXX opined the request for XX with XX and monitored anesthesia by an on-call XX was denied. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced above, this request is noncertified. As per evidence-based guidelines, epidural XX injection is recommended as a possible option for short-term treatment of XX pain (defined as XX) with use in conjunction with active rehab efforts. XX of the XX dated XXXX showed, at the XX, there was a broad-based XX XX with a XX, causing severe XX and mild XX XX. In this case, the patient reported pain and XX sensation. Failure from conservative treatments was not established as there were no actual PT reports submitted." Per a reconsideration review decision letter and peer review dated XXXX, the appeal request for XX XX was not approved. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. XX is recommended for short-term treatment of XX pain in conjunction with active rehab efforts. There must be documented XX, including objective signs and XX and / or XX and pain initially unresponsive to conservative therapy (exercises, XX methods, XX), XX, and XX). XX should be attributed to XX and not XX XX XX for the latter condition have not been shown to be as beneficial. In this case, the patient has objective signs of XX including XX sensation and XX in the XX extremity. XX dated XXXX documents a XX with mild XX which corroborates the findings of XX. The requesting physician has documented that the patient has attempted conservative therapy including XX and XX therapy. However, there have been no documents provided to confirm the failure of XX therapy. A peer to peer with XXXX was successful. I indicated to XXXX that I needed the XX therapy documentation and XXXX indicated that XXXX would email the information to me. I did not receive the information prior to the due date of the review. Therefore, the request for XX with XX and monitored XX by an on-XX is not medically necessary and is non-certified. The original denial 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 with XX and monitored anesthesia by an on-XX - Injection(s), XX agent and / XX, XX epidural, with imaging guidance (XX); XX or XX, single level, XX - Injection(s), anesthetic agent and/or XX, XX epidural, with imaging guidance (XX or CT); XX, each additional level, XX XX, radiological supervision and interpretation, XX - XX for XX is not recommended as medically necessary. There is insufficient information to support a change in the prior determinations, and the previous non-certification is upheld. There are no serial XX therapy records submitted for review. The Official Disability Guidelines note that XX is not routinely recommended for determining needle placement during a procedure such as epidural XX injection. The only medications being taken at this time are over the counter medications. There is no documentation of XX

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

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