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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX injection with sedation: 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. XXXX was diagnosed with XX, XX side and other XX XX XX, XX region. XXXX for a follow-up. XXXX reported that the XX epidural XX injection at XX-XX on the XX did not help XXXX and XXXX continued to have XX XX pain. On examination, XX walking was good. Flexion, extension, and rotation of the XX XX were normal. XXXX had an equivocal straight XX raise on the XX. On XXXX continued to have XX XX pain, which XX; however, XXXX was working full duty at the time. XXXX wished to get another injection. Examination remained unchanged from the prior visit except XXXX had quite tender XX XX XX at XX-XX. An XX / XX study dated XXXX showed XX abnormalities suggestive of mild irritation of the XX XX-XX and XX-XX nerve roots, the pattern of abnormality was most consistent with XX XX only. XX XX XX H-XX ruled out XX XX. The normal nerve conduction studies with XX XX activities in XX-XX and XX-XX XX muscles were also supportive of XX XX XX. Findings should be correlated with clinical and ancillary data to determine significance. The treatment to date included medication (XX) and XX XX epidural XX injection at XX-XX on XXXX without significant improvement. Per a peer review dated XXXX and utilization review decision letter dated XXXX, the request for XX XX epidural XX injection with sedation at XX-XX was denied. Rationale: "The injured worker has complaints of XX pain and underwent a prior XX-XX XX XX epidural XX injection without significant improvement. There is no indication of at least XX-XX% improvement for XX to XX weeks from prior epidural XX injection to warrant a repeat as

mandated by the guidelines. Hence, this request is not medically necessary." Per a peer review dated XXXX and reconsideration review decision letter dated XXXX, the appeal for XX XX epidural XX injection with sedation at XX-XX was not approved. Rationale: "Despite the XX findings, the last note of XXXX has conflicting information about the result of the epidural XX injection, so there is no verification XXXX had a therapeutic result to warrant repeating it. Also, the current examination has an equivocal XX straight XX raise, which is not a strong XX clinical finding to warrant doing an epidural XX injection as per Official Disability Guidelines."

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 XX epidural XX injection (XX) with sedation at XX-XX is not recommended as medically necessary, and the previous denials are upheld. Per a peer review dated XXXX and utilization review decision letter dated XXXX, the request for XX XX epidural XX injection with sedation at XX-XX was denied. Rationale: "The injured worker has complaints of XX pain and underwent a prior XX-XX XX XX epidural XX injection without significant improvement. There is no indication of at least XX% improvement for XX to XX weeks from prior epidural XX injection to warrant a repeat as mandated by the guidelines. Hence, this request is not medically necessary." Per a peer review dated XXXX and reconsideration review decision letter dated XXXX, the appeal for XX XX epidural XX injection with sedation at XX-XX was not approved. Rationale: "Despite the XX findings, the last note of XXXX has conflicting information about the result of the epidural XX injection, so there is no verification XXXX had a therapeutic result to warrant repeating it. Also, the current examination has an equivocal XX straight XX raise, which is not a strong XX clinical finding to warrant doing an epidural XX injection as per Official Disability Guidelines." There is insufficient information to support a change in determination, and the previous non-certification is upheld. Office visit note dated XXXX indicates that the patient had a XX epidural XX injection at XX-XX on the XX without significant improvement in XXXX pain. The Official Disability Guidelines require documentation of XX on physical examination corroborated by imaging studies and/or XX results. Physical examination on this date notes XX range of motion is XX and XXXX has an XX straight XX raising on the XX.

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