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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Therapeutic XX epidural XX injection XX on the XX.

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

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

☒ Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XXXX who was injured on XXXX, when XXXX developed a pop in the XX XX pelvic and abdominal area with a lot of increased XX pain and XX leg discomfort.

On XXXX, evaluated the patient for XX hip pain. The patient had difficulty getting up. The patient had XX hip and XX pain going into the XX leg. Associated symptoms included XX. The patient had a XX surgery in XXXX. XXXX was seen at XXXX and was diagnosed with herniated XX with XX leg radiculopathy. The patient was seen by XXXX and had XX. On exam, there was abnormal XX, restricted range of motion (ROM), tenderness in the buttocks and difficulty with heel/toe ambulation. There were sensory changes to light touch and pinprick in the XX XX thigh. There was positive XX and XX test. The patient was diagnosed with XX, XX XX and XX hip XX. XXXX prescribed XXXX. The handwritten report was partially illegible. The patient was released to restricted work.

On XXXX, XXXX., evaluated the patient for XX extremity pain. The patient was able to stand less than 30 minutes, able to sit for less than 30 minutes and able to walk less than 30 minutes. The pain level was 3-9/10. The pain was described as burning, sharp, numbness and tingling. The pain was better with XX. XXXX diagnosed XX XX extremity, foot pain, XX. The patient was referred to XXXX.

On XXXX, XXXX., noted the patient was XXXX and suddenly felt something pop in the XX XX area around the XX and then almost immediately started having a lot of generalized XX pain XX in the XX and some discomfort in XX XX, especially the XX leg. The main problem was a lot of XX pain. XXXX opined the patient needed evaluation of XXXX XX. Evaluating the XX was not going to do anything until it was made sure that the patient had no new ruptured XX. XXXX recommended XX scan of the XX XX.

On XXXX, XX of the XX XX performed at XXXX – Imaging showed XX and XX and lateral XX.

On XXXX, XXXX referred the patient XX to XXXX to try and evaluate the XX.

On XXXX, XXXX noted low XX pain radiating into the XX XX extremity. The pain level was 0-9/10. The pain was described as constant, burning, sharp, numbness and tingling. XXXX recommended evaluation of the XX.

On XXXX, XXXX noted no significant changes since the last visit. XXXX recommended followup as needed.

On XXXX, XXXX performed removal of failed XX column XX and battery with placement of new XX column XX.

On XXXX, XXXX noted the patient was still very sore but otherwise was doing reasonably well. XXXX provided wound care. XXXX opined the patient was too sore to be able to return to work.

On XXXX, XXXX evaluated the patient in a follow-up visit. The XX was programmed.

On XXXX recommended continuing restricted work.

On XXXX, XXXX evaluated the patient for low XX pain. The onset of pain was associated with twisting on XXXX. XXXX recommended referral to the patient's referring physician.

On XXXX, XXXX evaluated the patient for ongoing complaints. XXXX noted positive XX on the XX. There was a XX. The patient had poor toe and heel walking. Deep tendon reflexes were diminished in the XX extremities. XXXX ordered XX of the XX XX extremity, recommended PT and evaluation by referring physician.

On XXXX, XXXX noted low XX pain radiating into the XX XX extremity. XXXX recommended XX. The patient had a degree of anxiety about needles. The patient expressed a mental and/or psychological impediment to not have a degree of relaxation medication whilst this procedure was being performed.

On XXXX, XXXX noted no change in symptoms. The diagnostic XX was denied.

On XXXX, XXXX performed XX.

On XXXX, XXXX noted overall improvement in pain by more than a half. The patient was able to stand, sit, walk longer and could sleep better after the injection. The patient had decreased use of pain medicine. There was less stress. The patient was recommended to follow up in a month.

On XXXX, XXXX noted overall pain was better by more than 50%. XXXX recommended no injection at that time.

On XXXX, XXXX noted the pain would come and go. The pain was better with XXXX. The improvement in overall pain was by 50%. There was no change in physical exam since the last office visit. XXXX recommended repeat XX.

On XXXX, a request was submitted for therapeutic XX XX at XX-XX on the XX x1 (XX, XX, XX and XX).

On XXXX, performed a utilization review. The request for XX XX to the XX XX-XX with monitored anesthesia was denied based on the following rationale: *"The injured worker was diagnosed with a sprain of ligaments of the XX XX, initial encounter. There was no documented current evidence of radiculopathy on physical examination. XX imaging is inconsistent with nerve root impingement at XX-XX. Objective functional gains attributable to a prior epidural steroid were not noted in meaningful detail. Monitored anesthesia care is excessive for XX XX injections. XX epidural steroid injection to the XX XX-XX with monitored anesthesia is not shown to be medically necessary."*

On XXXX, XXXX was notified about the denial.

On XXXX, XXXX noted no change in the review of systems since the most recent visit. The patient was able to stand more than 30 minutes, able to sit for more than 30 minutes and able to walk for more than 30 minutes. The pain was 0-9/10. The pain was described as throbbing, sharp and aching. The pain was better with medication. On exam, the patient had poor heel and toe walking and positive XX XX. The patient wanted the XX to be removed and wanted the injections. XXXX recommended possible therapeutic XX and follow-up as needed.

On XXXX, appeal for therapeutic XX XX at XX-XX on the XX x1 (XX, XX, XX and XX) was submitted.

On XXXX, performed reconsideration and rendered the following opinions: *"The injured worker is a* XXXX *who sustained an injury on* XXXX. *The injured worker was diagnosed with a sprain of ligaments of the XX XX, initial encounter. Based on the submitted medical records, the injured worker has ongoing XX XX pain with radicular symptoms to both legs. Past treatments include at least one prior epidural injection which apparently provided 50% relief for 6-8 weeks. Pain has recurred and the treating provider would like to repeat the epidural injection with monitored anesthesia care. Guidelines support epidural steroid injections in cases where there are objective findings of radiculopathy corroborated by imaging studies. In this case, the injured worker has ongoing radicular pain but the physical exam did not fully support a diagnosis of XX radiculopathy with no mention of any myotomal weakness or dermatomal*

sensory changes in the XX extremities. Additionally, this request is for an epidural to be done with monitored anesthesia care. Excessive sedation is not recommended per guidelines for XX epidural injections. Given these factors, this request for XX epidural steroid injection to XX XX-XX with monitored anesthesia is not appropriate or medically necessary."

On XXXX, XXXX was notified about the denial.

On XXXX, XXXX noted ongoing complaints. The patient could stand for more than 30 minutes, sit for more than 30 minutes and was able to walk for more than 30 minutes. The pain level was 3-9/10. The pain was described as constant, throbbing, sharp and stiffness. On exam, there were no significant changes in the physical exam since the last visit. XXXX recommended follow-up as needed.

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

According to the ODG, the patient is in the therapeutic phase. As required, if after the initial block is given and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the therapeutic phase. Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year.

Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

The XXXX note documents that the patient had more than 50% improvement after the previous XXXX LESI, which is XX, decreased use of medications and an improved quality of life. In general, quality of life (QoL or QOL) is the perceived quality of an individual's daily life, that is, an assessment of their well-being or lack thereof. This includes all emotional, social, and physical aspects of the individual's life.

Radiculopathy has been documented in the XXXX note that includes poor toe and heel walking on the XX and positive XX.

Therefore, the ODG criteria are met and the XX XX injection at XX under fluoroscopy with XX due to anxiety is certified and medically necessary.

X Medically Necessary

☐ Not Medically Necessary

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES