Professional Associates P. O. Box 1238 Sanger, Texas 76266
Phone: 877-738-4391 Fax: 877-738-4395

Date notice sent to all parties: 10/23/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX at XX with fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Orthopedic Surgery
Fellowship Trained in XX Surgery

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

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

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

XX transforaminal ESI XX at XX with fluoroscopy – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

A XX MRI was obtained on XXXX. It revealed a XX mm XX XX at XX-XX without central canal or XX. There was moderated XX degeneration noted. At XX-XX, there was no XX XX or herniation and no central canal XX, but mild XX XX was noted. At XX-XX, there was XX desiccation and a XX mm broad based XX XX and moderate central canal XX. There was moderate to marked XX and moderate XX XX secondary to lateralizing XX XX. At XX-XX, there was mild XX degeneration and a grade I XX of XX on XX. A XX mm XX XX was also noted in addition to moderate to marked central canal XX secondary to XX and moderate to XX. At XX-XX, there was mild XX degeneration and a XX mm XX bulging. Mild central canal XX and moderate XX were also noted. XXXX examined the patient on XXXX. XXXX had had

pain since XXXX due to a work accident. XXXX had undergone ACDF at XX-XX and XXXX had XX pain that at times, would radiate to both XX extremities. The MRI was reviewed. XXXX was XXXX. The assessment was XX at XX-XX and XX radicular syndrome with XX at XX-XX and XX-XX. A transforaminal ESI under fluoroscopy XX at XX was recommended. XXXX XX exam that day showed decreased ROM and strength was XX/XX in the XX extremities. Sensation was intact throughout. DTRs were decreased, but equal. On XXXX, XXXX examined the patient for XXXX. XXXX had XX XX pain that radiated from the posterior hip down both. XXXX was currently on XXXX. XXXX was in mild distress and sensation was intact XX from XX-XX. Strength was normal from XX-XX and DTRs were XX+ in the patellas, but 0-1+ in the XX Achilles' and 1+ on the XX. XXXX gait was antalgic and SLR was positive on the XX for XX XX and radiating pain and on the XX for XX XX pain only. A transforaminal ESI XX at XX was recommended at that time. On XXXX, a precertification request was submitted for the XX XX

ESI with fluoroscopy. On XXXX., on behalf of XXXX, provided a non-authorization for the requested ESI. On XXXX, an appeal precertification request was submitted for the XX XX ESI. On XXXX., also on behalf of XXXX, provided another adverse determination for the requested XX transforaminal ESI at XX.

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

The requested transforaminal ESI XX at XX is not in accordance with the Official Disability Guidelines (ODG). The ODG discusses verifiable radiculopathy, in conjunction with a herniated XX. The ODG does not support performance of ESIs for conditions such as documented in this patient's case. The MRI scan in this case does not document a XX herniation, but rather multilevel degenerative changes with narrowing. The ODG does not endorse the use of ESIs in this instance, either. Furthermore, there are no objective physical findings. Lastly, the description of pain in only to the posterior hip, which is not radicular in nature. For these reasons, the requested XX transforaminal ESI XX at XX with fluoroscopy is neither reasonable nor medically necessary and is not in accordance with the recommendations of the ODG. The previous adverse determinations are therefore upheld at this time.

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**

☐ **AHCPR- 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**

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**