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An Independent Review Organization
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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX XX injection at the XX-XX level under fluoroscopy with IV sedation

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]:
This case involves a now XXXX with a history of an XX claim from XXXX. The mechanism of injury is detailed as a XXXX. The current diagnoses are documented as pain in XX shoulder, other XX displacement, XX, and radiculopathy to the XX region. Past treatment included medications, physical therapy, and XX steroid injection. On XXXX, it was documented this patient had complaints of pain to the XX spine. reported benefit from the prior injection. Upon physical examination, it was noted had tenderness to palpation and restricted range of motion to the cervical spine.

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

According to the Official Disability Guidelines, Epidural steroid injections are to reduce pain and inflammation thereby facilitating progress in an active therapy. They are to be given on the basis of radiculopathy that corroborates with imaging after the failure of conservative care. Repeat epidural steroid injections are given based on documentation noting at least 50% pain relief, decreased need for pain medications for six to eight weeks, and functional improvement from the previous injection. The clinical documentation submitted for review indicated this patient had benefit from the prior injection. However, there was no documentation noting quantified pain relief nor specifics regarding functional improvement. Further, duration of such relief was not specified and a rationale for IV sedation was not provided. Additionally, there was no documentation noting significant quantitative objective findings indicative of radiculopathy on

physical examination. Consequently, the request is not supported.

As such, the requested Cervical epidural steroid injection at the XX-XX level under fluoroscopy with IV sedation is not medically necessary and the prior denial 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

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, XX and XX (XX), Epidural steroid injection (ESI).