AccuReview

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[Date notice sent to all parties]: October 19, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX transforaminal XX Injection w/ fluoroscopy with monitored anesthesia.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board certified in Anesthesiologist with over 15 years of experience.

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

☒ Upheld (Agree)

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]:
XXXX: Office Visit dictated by XXXX. CC: recurrent XX and XX arm pain s/p work related injury and XX procedures. XX XX and XX leg pain s/p work related injury. DX: possible XX XX radiculopathy, multilevel XX degenerative XX disease with severe XX XX-XX and XX-XX with moderate lateral recess and this is XX XX-XX and XX XX-S1. TX: revision posterior XX decompression and instrumented XX arthrodesis XX XX-XX, XX-XX and XX-XX laminotomy with in situ fusion XX XX-XX and XXXX. Claimant continues with XX pain and arm pain located on the XX side. XXXX has had XX previous XX procedures culminating in a XX-XX XX fusion status post a work-related injury. Pain described as severe XX pain radiating to XXXX XX shoulder girdle and scapula extending with numbness and tingling to XXXX XX ulnar forearm and hand. XXXX describes subjective weakness about XXXX XX XX extremities as well as numbness and tingling on the XX in the ulnar distribution most closely. XXXX symptoms are XX/10 in intensity and XX and XX, XX and XX in character. Recurrent treatments have included use of narcotics, nerve pain agents, NSAIDs and activity restriction and symptoms persist. Medications: XXXX. Assessment: Possible XX XX radiculopathy s/p work related injury and XX previous XX surgical procedures. Multilevel XX XX disease with severe XX XX-XX and XX-XX with moderate lateral recess and this XX XX-XX and XX-S1. Recommend CT myelogram of the XX XX as well as an EMG of the XX XX extremities.

XXXX: Office Visit dictated by XXXX. CC: XX XX pain. The claimant complains of XX mid-posterior XX pain. XXXX is here for medication which does provide adequate relief enabling XXXX to function and need minimal assistance with ADL's and it helps XXXX QOL. XXXX is having problems with extension and almost passes our and decrease sensation XX XX and XX fingers. Current treatment includes: chiropractic manual medicine care and acupuncture. The current treatment is providing little relief of current symptoms. Reported associated XX, XX, XX and XX. Claimant has completed XX weeks of conservative care prior to this visit but not limited to PT, medications, and activity modification without improvement. PE: XX XX: kyphotic, point of

maximum tenderness: XX XX XX paravertebral. ROM limited in limited in all planes moderately due to pain. Impression: XX Facet Arthropathy XX XX-XX and XX XX-XX; post-operative XX surgery syndrome; anterior XX discectomy and fusion XX-XX; posterior XX fusion XX-XX; chronic pain; mechanical cervicalgia e/o facet vs. XX. Recommendations: activity modification to accommodate XX pathology. Medication prescribed: XXXX.

XXXX: Office Visit dictated by XXXX. CC: recurrent XX and XX arm pain. DX: adjacent segment degeneration XX-XX greater than XX-XX with possible XX XX radiculopathy s/p work related injury and XX previous XX surgical procedures. XX XX XX syndrome and XX cubital XX syndrome, multilevel XX. Claimant described some presyncope type symptoms occur when XXXX extends XXXX XX, encouraged to follow up with PCP for further evaluation. Relative to the XX XX, concerned XXXX may have some symptoms that every from XXXX XX-XX motion segment; send for XX XX selective nerve root block. Will also request a XX XX-XX facet block done simultaneously.

XXXX: CT C-XX with Contrast dictated by XXXX. Impression: Post-surgical and XX changes are noted.

XXXX: XX dictated by XXXX. Impression & Recommendations: 1. Delayed XX responses on both sides, 2. The median motor latencies are delayed bilaterally. The amplitudes of the median motor responses are fairly large and symmetric, XX. Delayed ulnar sensory response on the XX, XX. Ulnar motor conductions were done with recording from XX muscles. There is evidence of focal slowing in conduction velocity across the elbow segment. Amplitudes of the ulnar motor responses are lard ear all stimulation sites with no evidence of any significant conduction block seen in either side. XX. Needle examination surveyed multiple muscles receiving their innervation from the XX-XX nerve roots on both sides including ulnar half innervated muscles on the XX. The XX paraspinal musculature was deferred in light of previous XX XX surgery. All muscles tested were normal in their insertional activity. There was no evidence of any abnormal spontaneous activity. All motor units observed in the muscle examined were normal in their XX, XX, XX and XX. Impression: no electrodiagnostic evidence of a XX or XX XX-XX XX, XX evidence of XX XX A. mild, B. findings of focal slowing in conduction velocity across the elbow segment with a drop XX for the across elbow velocity, C. XX of XX proximal ulnar neuropathy. Electrodiagnostic evidence of XX median neuropathy at the wrist: moderate, XX slightly > XX, affected. Medications added: XXXX.

XXXX: XR -XX dictated by XXXX. DX: no significant extradural defects are noted. XX nerve root sleeves appear to be adequately filled.

XXXX: UR performed by XXXX. Reason for denial: Regarding the request for transforaminal ESI with fluoroscopy with monitored anesthesia; XX (XX XX), the claimant did complain of XX and XX arm pain. The physical exam also revealed flexion was fingers, and extension was 30 degrees with radiating pain. However, XX transforaminal ESI is not recommended per guidelines. Request is not medically necessary.

XXXX: UR performed by XXXX. Reason for denial: The request was previously noncertified as the procedure was not recommended by the guidelines and there was a lack of documentation to support radiculopathy. No additional documentation was submitted to support the request. The previous noncertification is supported. According to the guidelines, XX ESI is not recommended given the serious risks of the procedure and the lack of quality evidence for sustained benefit. If performed, the guidelines state there must be evidence of radiculopathy on clinical examination and diagnostic imaging. There is no evidence of radiculopathy on clinical examination and diagnostic imaging at the requested level of injection.

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

Based on the records submitted and peer-reviewed guidelines, the previous noncertification is upheld. Per ODG,

XX ESI is not recommended given the serious risks of the procedure and the lack of quality evidence for sustained benefit. If performed, the guidelines state there must be evidence of radiculopathy on clinical examination and diagnostic imaging. There is no evidence of radiculopathy on clinical examination and diagnostic imaging at the requested level of injection. This request was previously noncertified as the procedure was not recommended by the guidelines and there was a lack of documentation to support radiculopathy. No additional documentation was submitted to support the request therefore, the request for XX XX transforaminal Epidural Steroid Injection with fluoroscopy with monitored anesthesia is non-certified.

Per ODG: XX

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**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **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)**