

MEDRx

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DATE OF REVIEW: April 4, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

XX epidural steroid injection w/fluoroscopy performed under anesthesia

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

The reviewer is a Medical Doctor who is board certified in anesthesiology/pain management.

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the medical necessity of: XX epidural steroid injection w/fluoroscopy performed under anesthesia

PATIENT CLINICAL HISTORY [SUMMARY]:

Upon examination on XX claimant had persistent XX, XX, and XX pain despite appropriate XX therapy rehabilitative care. Ultimately, MRI of XX XX was performed and was consistent with moderate size XX XX/XX most notably at XX-XX, XX-XX and XX-XX with definite XX nerve root involvement. Claimant has multi-level XX XX/XX throughout XX XX XX as well as a mild XX XX XX more XX at XX-XX. Claimant's XX pain is worse with coughing, sneezing, and lifting. XX feels numbness down XX XX XX as well as XX XX at time. Conservative treatment including NSAIDs, XX pain medicine, XX XX, and XX XX has been tried but with no avail. XX has tried numerous XX therapy modalities. XX CESD has become worse as XX affect has worsen and XX's XX XX about XX future return to work, XX XX, and perform as

XX. XX CESD was 19/60 and XX GAD-7 was 4/20 showing good XX levels manageable. Claimant was diagnosed with XX strain.

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

This request is not medically necessary and is non-certified. Per the Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition, Chapter: XX XX- XX and XX:

Epidural steroid injections (ESIs), therapeutic:

XX.

Criteria for the use of Epidural steroid injections:

Note: XX. Therefore, this request is not medically necessary and is non-certified.

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 KNOWLEDGBASE
- 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)**