CASEREVIEW

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X: MRI X
X: Pre ESI Consult by X, MD
X X Study
X : Special Interventional Radiology Consult by X, MD
X : Interventional Radiology Consult by X, MD
X: ESI Report by X, MD
X : Patient Follow-Up Report by X, MD
X: UR performed by X, MD
X: UR performed by X, MD

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XX year old X who was injured on X.

On X, MRI X Impression: X/X indents the X. X are patent.

On X, the claimant presented to X, MD for continued moderate X that radiated to the X leg. X described X in the X extending to the X. On exam X had a XX. Impression: 1. The patient is in significant pain and has not responded to X. The patient appears to be a candidate for a X. 2. Plan: Schedule patient for X.

On X, X Study Impression: Findings are most consistent with an X suggestive of X with some X evidence of _____.

On X, the claimant presented to X, MD with significant X pain. X described the pain as X. X also described X on the side of the X extending to the X. On examination there was X at the X. X was normal. X was normal. Positive X. Impression: X and X. X. Candidate for an X.

On X, the claimant presented to X, MD with continued significant back pain after denial of X Dr. X stated that an X on X describes an X suggestive of X and therefore the patient is a candidate for XX.
On X, the claimant underwent a successful performed by X, MD.

On X, the claimant presented to X, MD following an X. The patient rated X pain X compared to X prior to the X. X pain had improved and X was able to X and perform most daily activities, however X still had X pain in the X that radiated to the X. X was prescribed X. An additional X was recommended.

On X, X, MD performed a UR. Rationale for Denial: The Official Disability Guidelines, X chapter, only supports repeat X if there is at least X pain relief, as well as increased ability to function with prior injections. There should also be documentation of decrease medication use. This patient received an injection only three weeks ago and although there is decreased pain and increased function, there is no mention of decrease medication use. Additionally, there is no repeat X performed indicating the presence of the radiculopathy to support another injection. Accordingly, this request is not supported. Furthermore, during the peer discussion with Dr. X, the

patient was seen for a X relief but was not able to go back to all daily activities. Patient started with X pain, it was stated. After speaking with the provider, the patient is only X weeks out form XX. While the patient has had X relief, X has not had sustained relief for a X week time period. Therefore, the request is not supported at this time.

On X, X, MD performed a UR. Rationale for Denial: The Official Disability Guidelines state that criteria for repeat X includes documented evidence of at least X pain relief for at least X weeks. Additional X should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. In this case, the request was previously denied as the patient did not have evidence of appropriate X -week duration of sustained relief, as required by guidelines. The provider does note that the X provided X pain relief, and improved X ability to perform activities of daily living. However, there was no evidence of a X that the pain relief had lasted X, as required by guidelines. Next, there was no documentation of a decreased need for pain medications. As such, guideline criteria for a repeat X have not been met. There were insufficient findings to support overturning the period determination. Therefore, the appeal request for X is non-certified.

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

The request for X is not found to be medically necessary. The claimant is a X year-old X who was injured in X. X has X pain with X. X MRI demonstrates a X. X underwent a XX. Following this X, X pain level improved from X. A second X was recommended on X.

The Official Disability Guidelines (ODG) supports a X in patients who have reported X pain relief for at least X weeks after the X. Documentation of pain relief, decreased need for pain medication and functional response are necessary for repeat X. The X was requested within X weeks of the X. There is no documentation of sustained pain relief at X weeks. In addition, it is unclear whether the X had any effect on the patient's need for pain medication. The X is not medically necessary based on the records reviewed.

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 LOW BACK 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)**