INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Records were received and reviewed from the following parties: XX Claims Management Services

These records consist of the following (duplicate records are only listed from one source): Records reviewed from XX Claims Management Services:
XX Clinics/XX , MD/XX
- Preauthorization Request-XX
- Patient Referral-XX
- Referral Prescriptions-XX
- Consultation Report-XX
- Recheck Injury Flowsheet-XX
- Injury Recheck Encounter Notes-XX
- Office Visit Notes-XX
- Progress Notes-XX

XX MRI & Diagnostic Center:
- MRI Report-XX

XX :
- Radiology Report-XX
- Office Visit Note-XX

XX :
- Denial Letters-XX

XX MD:
- Peer Review Report-XX

XX:
- Pharmacy Benefit Form-XX

XX MD:
- Office Visit Note-XX

XX MD:
- Peer Review Report-XX

XX

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XX year-old XX who sustained an injury while XX XX pounds. Per examination on XX/XX/XX, the patient has a XX at XX and XX and has been incapacitated since then, unable to work, XX pain radiating to the XX extremity. He has tried XX and XX without significant improvement. Current treatment includes XX and medications include XX and XX.

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

Per evidence-based guidelines, and the records submitted, this request is non-certified. Patient continues to have pain in the XX extremity. Per ODG, to justify XX, there must be XX demonstrated by XX and XX by imagining studies and/or XX studies. In addition, there must be demonstrated failure of XX therapy. Based on the records submitted, there is no clear objective evidence of XX at two levels on XX and no XX was submitted. There is no indication that patient has failed XX therapy. The MRI report does not indicate the presence of XX compression at the two levels to be injected. There is no indication that the patient has been instructed in home exercises to do in conjunction with injection therapy. Furthermore, there was no documentation the patient had significant XX to want the requested sedation. Therefore, this request is not medically necessary.

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition
Chapter: XX

Criteria for the use of Epidural steroid injections:
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 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)**