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PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured at work on X. The biomechanics of the injury were not found in the medical records. X gave a longstanding history of X pain while working in X and multiple X including a X. The ongoing diagnosis was X. X was evaluated by X, DO on X for follow-up care regarding X complaints associated with X. X felt that was the worst XX X had in years. X reported moderate X, pain with X. X felt the medications were no longer helping X as they previously did. X was on X to help with X and X as a X. X pain continued to be X on this drug regimen. As a result, Dr. X recommended X stating it worked very well in X associated with the injury. X was representing X. However, X knew this was a good procedure for X. As a result, X in the prone position was recommended, as this was a painful procedure entry into the X. Any further delays in this treatment would lead to more X pain complaint. Per a Follow-Up Note dated X, Dr. X stated that X was very disappointed, as X was not approved for the treatment that Dr. X had set to help X, which, over a year prior, helped X recover from X pain associated with post X and X work injuries. X described X pain in X. Previous X had stabilized the pain, lessening X use of X. Due to the inappropriate denial, X felt that X pain was getting worse. X looked in the extremes, reporting pain scores of X. Dr. X documented he would hold off on any further adjustments on X medicine because they were at a fairly strong dose of X used in conjunction with X, maximum dose used in conjunction with X pain medicine and X support in the form of X at night. X was noted to be walking with an X. X had moderate X with a positive X. X had decreased X distribution. As a result of increased X associated with the denial, X Center for X Studies (X) scale

score was X and X generalized X -score was X. Dr. X noted that further delays in the treatment would lead to more X pain complaint. A CT scan of the X dated X revealed X. There was X. X was noted surrounding the posterior aspect of the X. There did not appear to be movement of the X. This could be evidence for X. There X. There was X that touched and likely displaced the exiting X. Marked X was noted with X due to X. A XX XX screen dated X was positive and inconsistent for X. Treatment to date consisted of medications (X). Per a utilization review determination letter dated X and a peer clinical review report dated X by X, MD, the request X approach with X performed under X, X, was non-certified. It was determined that X sustained an injury on X and had X associated with X. X had a positive X, moderate X, and decreased X distribution. Dr. X noted that the previous X provided functional gains, decreased medication use and X pain relief. Official Disability Guidelines stated that if after the X were given and found to produce at least X pain relief for at least X weeks, additional X might be supported. Despite multiple denials for previous X requests, there was still no documentation of how long the X lasted despite providing X pain relief. The guidelines also stated that additional X might be supported if the initial X lasted for at least X hours. Therefore, the request was still not medically justified, and it was recommended to be non-certified. Per a follow-up note by Dr. X dated X, X had continued to X. X was more X, and X had come down. X was being treated for X. X hardware was problematic. However, with X, X had received more than X improvement over a year prior. X main pain was X. X was willing to lower X. X needed something including X as a X. X used the X with good results for the X that X often had and X. Due to the protracted use of this medicine, X required X to help with X. X had a X, and consistent with Official Disability Guidelines, X might receive X per year for X pain complaints and Dr. X would go ahead for this, pending insurance authorization. Due to X status, X was on X. X was suffering from X. Dr. X recommended X, as X complained of X. Dr. X documented that X had lost over X pounds under his care and X pain had come down to X, and that further gains may be made with X. Per a utilization review determination letter dated X and a peer clinical review report dated X by X, DO, the request for X was denied. Rationale: “With regard to the X, according to an office note on X, there was documentation of the injured worker having history of a X and was reportedly more functional and more active and continued to X. Physical exam revealed X, and no other physical exam findings were listed. There was also documentation that with X over a year prior, the injured worker received more

than X improvement and the plan to do a repeat X with the main pain in the X along with X for pain. However, there is no documentation detailing the specific duration of pain relief achieved with the last X and what specific overall functionality was achieved and whether significant pain medication reduction occurred. Furthermore, there is no documentation of on exam such as decreased X, and guidelines indicated X should be avoided. Therefore, this request is not in accordance with the guideline criteria and is non-certified. Per a follow-up note by Dr. X dated X, X continued with moderate-to-severe X pain associated with X as noted by X pain having X. X was taking X on going X on a steady basis with reportedly good results. X was recommended. Unfortunately, a reviewer, who was not educated, trained or experienced in interventional pain care, had rendered opinions outside the Official Disability Guidelines and as practiced by Dr. X, a Board Certified Fellowship pain specialist. As a result of the denial, X was requiring X. This was in contradiction to the Texas Medical Board's desire, which was to get people X, get people well, and get them back to their former level of activity at work. X might be considered in the future. However, X consistent with the Official Disability Guidelines as an epidural approach for recurrent XX disorder associated X as evidenced by moderate pain in the X with X test at X degrees on the X with decreased X, would require interventional pain care. As a result of the denial and X increased pain keeping X in bed at times, Dr X was going to raise X. He would resubmit for the denied procedure. A reconsideration (appeal) review adverse determination letter and a peer clinical review report dated X, by X, MD, indicated that the appealed treatment / service request was non-certified. Rationale: "Within the associated medical file, there is documentation of subjective findings of X pain. The injured worker reports X. Objective findings include a X. There is moderate X. The provider notes that X has a fear of X which is the need for X. The provider notes an X over a year ago with more than a X improvement. On the X determination, the reviewing physician non-certified the request for X citing the rationale, 'According to an office note on X, there was documentation of the injured worker having history of a X and was reportedly more X. Physical examination revealed X, and no other physical exam findings were listed. There was also documentation that with X over a year ago, the injured worker received more than X improvement and the plan to do a X for pain, however, there was no documentation detailing the specific duration of pain relief achieved with the last X and what specific overall functionality was achieved and whether significant pain medication reduction occurred. Furthermore, there

is no documentation of X on exam such as X and guidelines indicate X should be avoided. Therefore, the request is not in accordance with the guideline criteria and is non-certified.' However, there is no documentation of X on exam such as decreased X. In addition, there is no clear documentation of reduced medication use or functional benefit or duration of relief from the prior X. Therefore, I am recommending non-certifying the request for X.

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

The Official Disability Guidelines discusses indications for X. X are generally recommended early in the course of an injury in order to facilitate initial active functional restoration. This treatment is generally not recommended in a chronic postoperative settings such as currently. Moreover, when an X is indicated generally the indication is a X confirmed via symptoms, examination findings, and diagnostic studies which correlate at a particular nerve root level; such symptoms are not present at this time.

Considering these factors overall, this request at this time is not medically necessary and should be non-certified.

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