I-Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd Ste 117-501
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 790-2280
Email: manager@i-resolutions.com

December 6, 2018

Description of the service or services in dispute:

XX

Description of the qualifications for each physician or other health care provider who reviewed the decision: Board Certified Anesthesiologist

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

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

Patient Clinical History (Summary)

XXXX. XXXX was diagnosed with XX of the XX region (XX.XX) and XX XX pain (XX.XX).

On XXXX for a follow-up. XXXX reported moderate-to-severe XX pain, XX XX, and leg pain. The pain was XX-XX/10. XXXX walked with an XX XX and gait. XXXX noted that XXXX's MRI had been corroborated to include an XX-XX XX disc. XXXX physical findings were consistent with XX XX XX. Over XX weeks prior, XXXX had got XX epidural blockade with excellent relief of pain, more than XX% improved function, and decreased medication requirement. After the first block, XXXX had lost over XX pounds and become more functional and more active. Due to denial of the requested service, XXXX was asking for further medication because XXXX could not perform XXXX activities of daily living. XXXX documented that XXXX had XX of XX and XX. XXXX had an XX XX status. XXXX also had a XX XX XX. Despite XXXX improvement, they would require intravenous sedation in the XX position with appropriate monitoring. As a result of the denial, XXXX raised the medications including XXXX XX times per day; this was in complete contradiction to the XXXX which supported interventional pain care and XX analgesia. XXXX requested XX epidural injection therapy at the XX-XX XX under intravenous sedation in the XX position. XXXX also documented that delay would only lead to more disability, pain, and increased healthcare cost.

XXXX was seen by XXXX on XXXX for a follow-up of XX, XX, and XX pain. XXXX had failed conservative rehabilitative care. XXXX got well following XX epidural blockade with more than XX% improvement of pain, improved function, and decreased medication. XXXX noted that with the denial of

care, XXXX was going to be requiring ongoing XX analgesia, as XXXX continued to perform activities of daily living both at home and in the community. XXXX was noted to walk with an XX XX that day. The physical findings at the time were again consistent with XX disc XX and XX XX. XXXX recommended a repeat MRI analysis.

A XX drug screen dated XXXX was XX for and XX with XXXX.

An MRI of the XX XX dated XXXX revealed no compression fracture or spondylolisthesis. There was disc XX with XX disc XX identified at XX-XX, XX-XX, and XX-XX with slight XX of the XX sac at XX-XX. Slight XX XX-XX XX recess, XX neural XX XX was also noted along with XX XX XX with multiple XX.

The treatment to date included medications (XXXX), XX epidural steroid injections (minimal temporary relief), exercise, and physical therapy.

Per a utilization review decision letter dated XXXX, the requested service of XX epidural steroid injection at the level of XX-XX under fluoroscopy with intravenous sedation was denied by XXXX. Rationale: Per evidence-based guidelines, repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. However, there was limited documentation of objective functional improvement from prior injections to warrant the need for an additional injection. There was also no clear documentation that XXXX had exhausted and failed conservative treatments. There was also no documentation if it would be used in conjunction with active rehabilitation efforts, and exceptional factors were not identified to warrant the requested treatment. Thus, the request was not medically necessary. The clinical notes provided demonstrated that on XXXX, an epidural steroid injection (ESI) did not produce relief. There was no clarification in the clinical notes of the need for this ESI. Moreover, there was no documentation that injections were in conjunction with a home exercise program (HEP).

Per a utilization review decision letter dated XXXX, the prior denial was upheld by XXXX. Rationale: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, the request was noncertified. ESI is recommended for short-term treatment of XX pain in conjunction with active rehabilitation efforts. There must be documented XX including objective signs and corroborated by imaging studies and / or electrodiagnostic testing and pain initially unresponsive to conservative therapy (exercises, physical methods, nonsteroidal anti-inflammatory drugs, muscle relaxants, and XX drugs). XX should be attributed to XX XX XX and not XX XX as ESIs for the latter condition have not been shown to be as beneficial. A repeat ESI should be based on objective pain relief, reduction in medication use, and improved function. A repeat ESI is not indicated if there is an inadequate response to the first block XX percent relief). In patients with initial pain relief of XX-XX% for XX to XX weeks and an acute exacerbation of pain or new onset of XX pain, a repeat ESI is an option. No more than XX injections should be considered per region per year. Furthermore, guidelines require objective signs of XX to support a diagnosis of XX. XXXX had a prior XX XX-XX ESI on XXXX. MRI dated XXXX documented at XX-XX, a disc XX and XX XX XX on the XX, which corroborated findings of XX. XXXX continued to have pain despite prior physical therapy. Per the medical record dated XXXX, the physician stated that XXXX had "Excellent relief of pain, more than XX% improved function, and decreased medication requirement. This was all identified in our subsequent follow-up notations." XXXX was in possession of medical reports dated XXXX (five weeks after ESI), and XXXX (one week after ESI). Contrary to the requesting physician's statement, there had been no objective evidence of improved function

or pain on any medical record after the procedure on XXXX. Furthermore, guidelines required objective signs of XX to support a diagnosis of XX. The requesting clinician had provided little-to-no physical examination findings to support a diagnosis of XX. There had been no physical examination findings documented on any of the previously mentioned medical records that indicated a decrease in sensation, reflexes, or strength in a XX / XX distribution. Therefore, the request for XX Epidural Steroid Injection under Fluoroscopy with IV Sedation XX-XX was not medically necessary and was noncertified. The original denial was upheld.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient presents with a XX for which a repeat ESI was requested. The provider reported that the patient's response to a prior ESI was positive and produced more than XX% pain relief. The patient has XX XX but is still XX XX XX.

Two prior reviews were conducted both of which denied a requests for a repeat ESI at XX-XX. The first review cited documentation issues respect to objective functional improvement from the prior ESI. There was also a lack of a clear therapeutic plan following the ESI, in the form of a HEP. A second review also cited documentation issues. Specifically, there appeared to a conflict of opinions as to whether the prior ESI in XXXX was effective. It was further noted that documentation of a clinical XX was lacking in the providers records.

This reviewer finds the prior reviews to be accurate and reasonable. The hallmark of the ODG recognition of the need for an ESI is clinical evidence of XX which is lacking. In addition, there is some debate as to whether the prior ESI was effective. There are conflicting reports, which preclude any approval process. It is acknowledged that this patient would need XX during such as procedure, but since the ESI is not indicated, the XX request is irrelevant. Given the documentation available, the requested service(s) is considered not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

☐ ACOEM-America College of Occupational and Environmental Medicine

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines

☐ DWC-Division of Workers Compensation Policies and Guidelines

☐ European Guidelines for Management of Chronic Low Back Pain

☐ Interqual Criteria

☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards

☐ Mercy Center Consensus Conference Guidelines

☐ Milliman Care Guidelines

☐ ODG-Official Disability Guidelines and Treatment Guidelines

XX
XX

☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.