C-IRO Inc.

An Independent Review Organization
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11/26/18

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 XX pain and XX XX displacement with XX at XX XX and XX.

On XXXX evaluated XXXX for XX XX pain. The pain was located in the XX XX XX XXX region. XXXX described the XX XX pain as XX, XX, and XX in intensity. The pain score was an average of XX-XX/10, worst pain of XX/10, and least pain of XX/10. XXXX stated that the pain worsened by activity and lifting. The pain was made better by sitting. The XX XX pain was gradually worsening from the onset. XXXX reported that XX therapy re-injured XXXX back by having XXXX to lift XX pounds. On examination, XXXX was in mild XX. XXXX XX without assistance or assistive device. XXXX was able to transfer from a sitting position to the examination table without difficulty. The XX XX examination showed the point of maximum tenderness in the XX-mid XX XX and XX XX XX XX area. The range of motion was limited in extension and XX by pain, extension was greater than flexion. The seated straight XX raise test was XX on the XX for XX XX pain. The XX XX reflexes (XX) was XX+/5 and XX XX (XX) was XX+/5.

An MRI of the XX XX dated XXXX showed XX XX XX XX at XX-XX related to XX XX XX measuring approximately XX.XX mm. There was a XX XX XX measuring XX mm without XX at XX-XX and a XX.XX-mm XX XX versus a XX root XX XX within the XX XX exit XX at XX-XX involving the XX XX XX roots.

The treatment to date included failed nonsteroidal anti-inflammatory drugs (NSAIDs) and muscle relaxant, XX therapy exercise program without relief, and home exercise program.

Per a utilization review adverse determination letter and peer review dated XXXX, the request for XX XX and XX XX epidural steroid injection with fluoroscopy and monitored anesthesia was denied. Rationale: "Per evidence-based guidelines, epidural steroid injection (ESI) is recommended to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, the reduction of medication use and the avoidance of surgery, but this treatment alone offers no significant long-term functional benefit. XX must be corroborated by imaging studies and / or electrodiagnostic testing. Per medical, the patient was recommended XX epidural steroid injection at XX XX and XX with fluoroscopic guidance. However, the MRI of the XX XX dated XXXX had XX significant findings of XX root XX at the specific XX level requested for injection. In addition, there was limited evidence if the patient had failed from lower levels of care such as exercises, physical methods, NSAIDs, muscle relaxants, and XX drugs prior to considering the injection as there were limited medicals submitted. Clarification is needed regarding the request and how it might affect the patient's clinical outcomes. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Limited information provided that if the patient had failed from lower levels of care such as exercises, physical methods, non-steroidal anti-inflammatory drugs, muscle relaxants, and neuropathic drugs prior to considering the injection. Moreover, limited imaging findings correlating with pathology at the region requested for injection."

Per a reconsideration review adverse determination letter and peer review dated XXXX, the appeal for XX XX and XX XX epidural steroid injection with fluoroscopy and monitored anesthesia was not approved. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per guidelines, epidural steroid injections are recommended as possible options for short-term treatment of XX pain with corroborative findings of XX in imaging studies for use in conjunction with active rehab efforts after initial unresponsiveness to conservative treatments. MRI of the XX XX on XXXX showed XX XX XX XX at XX-XX related to XX XX XX measuring approximately XX.XX mm. There was a XX XX XX measuring XX mm without XX at XX-XX. A XX-mm XX XX versus a nerve XX XX XX within the XX XX exit XX at XX-XX involving the XX XX nerve roots. A request for transforaminal injection with fluoroscopic guidance was made; still, a detailed objective evidence of a recent, reasonable and / or comprehensive non-operative treatment trial and failure should be considered prior to considering higher levels of care. Also, there was still limited documentation of objective significant findings in the recent examination that would validate signs of radiculopathy."

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

The question at XX is whether this patient is eligible for a XX XX-XX XX ESI with fluoroscopy and monitored anesthesia care. The patient was injured in XXXX, and since then has undergone medical management including muscle relaxants and NSAIDs, XX therapy and home exercise program. This information was stated in the provider's clinical notes. The clinical presentation in this patient is somewhat ambiguous, although there is evidence of clinical XX XX involvement on the XX at XX-XX. The MRI shows multilevel disease, but with a prominent XX XX abnormality at XX-XX on the XX. This abuts the XX XX XX root, and therefore may be the primary source of the patient's pain. Two URs were performed and both were not convinced by the lack of an evidentiary basis for the ESI. In addition, the reviewers reported that the conservative care was too limited, and that the evidentiary basis for a non-operative trial was lacking.

Both reviews have some merit, but with XX XX XX XX, this reviewer cannot envision what more conservative therapy – i.e. medications and PT will achieve. The MRI does not show classic XX XX with major XX XX, but the MRI of the XX XX column is non-negative. So, the requested procedure, as a diagnostic intervention, may shed more light on the patient pain generator and may clarify the need for operative intervention. Given the documentation available, the requested service(s) is considered medically necessary.

With regard to the request for monitored anesthesia care (MAC), the patient has not manifested any XX XX or XX XX, as per the chart documentation. However, XXXX works in XXXX, and probably, the use of XX in XXXX XX for the first time, may be associated with XX reflexes and excess movements on the table. The ODG recommends avoidance of excessive sedation, which MAC provides.

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
- ☐ 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.