C-IRO Inc.

An Independent Review Organization
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Description of the service or services in dispute:

XX epidural steroid injection (ESI) x2, XX
XX - Injection(s), of diagnostic or therapeutic substance(s) (eg, XX), not including XX substances, including needle or XX placement, XX epidural or XX, XX or XX

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

Board Certified in PM&R
Board Certified in Pain Management

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. The ongoing diagnoses were XX, XX XX of the XX region, XX of the XX region, XX of the XX region, and other XX XX XX, unspecified XX region.

On XXXX for a follow-up. XXXX had been sent back to have a series of XX XX epidural steroid injections (XX) XX weeks apart for XXXX XX pain with XX. The pain was XX/10. XXXX had undergone XX on XXXX with XX% relief of XXXX XX pain. At the time, XXXX stated that the pain had returned to baseline post-injury. On examination, the XX was stiff. There was a decreased range of motion with XX extension, XX flexion, and rotation; and pain with XX extension, XX XX flexion, and XX directions rotation. The reflexes were XX+ over the XX, XX, and XX. The plan was to proceed with XX XX epidural steroid injection at XX.

XXXX. XXXX complained of XX XX. The location of discomfort was XX. It radiated to the XXXX XX and XX XX. The pain was characterized as moderate in XX, XX, XX, XX, XX, and

XX. The symptoms were secondary to XXXX injury in XXXX. The associated symptoms included XX XX. Examination of the XX revealed XX. There was decreased range of motion with XX extension, XX flexion, XX rotation, and pain with XX extension, XX lateral flexion, and XX rotation. Rotation of the XX to the XXXX caused pain in the XXXX XX region. The reflexes were XX on the XXXX and 0 on the XXXX over the XX, XX, and XX. The plan was to proceed with a XX XX XX steroid injection at XX.

XXXX for a follow-up of XX and XX pain. The overall symptoms remained the same as the prior week. XXXX was a XX XX with XX weather, question tightening up. The pain was XX/10. A prescription for XXXX was provided. XXXX to return to work as of XXXX without restrictions. The handwritten medical record was largely illegible.

An electromyography / nerve conduction (EMG / NCS) study dated XXXX showed mild-to-moderate, XX-to-XX, XXXX, XX, XX, and XX XX. There was mild-to-moderate, XXXX, XX, XX XX at the XX (XX). Mild, XXXX, XX, XX XX syndrome was also noted.

The treatment to date included medications (XXXX) rest, activity modification, home exercise and physical therapy (no relief in pain), massage therapy (not helpful), and XX injections (XX% relief). XXXX primary care provider stated that XXXX could no longer take XX XX-XX drugs (XX) due to XXXX XX functions.

Per a utilization review decision letter dated XXXX, the requested service of XX epidural steroid injection (ESI) x2, XX XX was denied. Rationale: "With regard to the request to the XX epidural steroid injection, this request is not supported. This type of treatment is not recommended given the serious risk of this procedure in the XX region and lack of quality evidence for sustained benefit. The patient had received previous epidural steroid injection with claims that XXXX had XX% pain relief for XX weeks following the injection. However, patients are required to have at least XX% pain relief for XX weeks with evidence of objective functional improvement and indication of reduced pain-relieving medications to support repeated injections. The documents did not confirm which levels of the XX XX the patient had received the previous injections to determine if the current request was for repeated treatments at the same levels. Furthermore, the request for XX injections would not be supported without evidence of significant response to an initial course of treatment utilizing this particular modality. Moreover, the physical examination conducted on XXXX did not identify any XX symptoms in the XX or XX XX that would indicate XX to support an additional epidural steroid injection. Based on these findings, the current request is not supported. As such, the request for XX ESI x2, XX XX-outpatient is non-certified."

Per a utilization review decision letter dated XXXX, the prior denial was upheld by XXXX. Rationale: "Regarding the XX epidural injection, the patient complained of XX XX pain and was previously treated with rest, activity modifications, XX therapy, medications, and XX injections. This case was previously denied due to the levels of the XX epidural injection previously received were unknown and no evidence of significant response to initial course of treatment. The examination also did not identify any XX symptoms in the XX XX. It was noted that on XXXX, the patient received a XX epidural injection with XX% reduction in pain for greater than XX weeks. The patient had almost XX range of motion of the XX XX. However, the pain slowly

returned with an increased level of pain not returning for greater than XX weeks. Until that time, the patient had XX% relief of the XX pain as well as the XX pain. The pain had now returned to XX post-injury. The patient reported that the pain XX to the XX. On examination, there was decreased range of motion of the XX XX. Sensation was XX to touch, pinprick, vibration, and proprioception. XX out of XX motor strength was also seen in all major muscle groups However, the clinical note dated XXXX, failed to provide examination findings of significant neurological deficits such as decreased motor strength and decreased sensation in a specific XX or XX distribution. There was also a lack of documentation regarding the decreased need for pain medication. There was also no official magnetic resonance imaging (MRI) submitted for review. Lastly, the guidelines state that epidural injections are not recommended based on recent evidence, given the serious risks of this procedure in the XX region and the lack of quality evidence for sustained benefit. Given the above, the request for XX epidural steroid injection (ESI) x 2. XX XX, outpatient is non-certified."

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

The Official Disability Guidelines discusses XX epidural steroid injections. This form of treatment is "not recommended" given concerns in particular by the FDA regarding potential morbidity/mortality from this procedure. Moreover, this patient previously has undergone XX epidural steroid injections. The medical records outline largely subjective benefit but do not clearly document specific objective improvement or medication reduction from such prior injections, as would be indicated before consideration of repeating such an injection. Additionally, I note that when an epidural steroid injection is an option, generally injections are a consideration in situations when a patient has symptoms, exam findings, and diagnostic studies which correlate to confirm a XX at a particular level. Such clinical findings are not present at this time and thus again an indication for an epidural steroid injection is not apparent. Additionally, when epidural steroid injections are utilized, generally treatment guidelines recommend such injections early in the course of an injury in order to facilitate initial functional restoration; epidural steroid injections are generally not recommended in the treatment guidelines in a chronic setting such as currently.

The medical records do not contain a rationale for an exception to the guidelines given these multiple concerns. Therefore, in this situation the request is not medically necessary and was appropriately non-certified.

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.