True Decisions Inc.

An Independent Review Organization
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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Pain Medicine

REVIEW OUTCOME:

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a now -year-old XXXX with a history of an XX claim from XXXX. The mechanism of injury was described as the patient was XXXX. The current diagnoses were documented as XX XX. On clinical note dated XXXX the patient was seen for chief complaint of XX XX pain. The patient described the XX XX pain as aching, was present constantly and varied in intensity. The patient reported that the pain was made worse by XX and/or XX. The pain was made better by XX XX and XX. The patient reported that the XX XX pain had gradually worsened since its onset. XX XX XX pain was noted in the XX XX. The patient describes XX XX XX symptoms as XX and XX. The patient reported that XXXX was present constantly and varied in intensity. The symptoms were made worse by same thing that aggravated the XX XX. The symptoms were also made better by the same items that assist with XX XX pain. The symptoms were also gradually XX since its onset. The following diagnostic testing was conducted, x-rays of the XX XX. It was reported that the following treatments failed to provide relief of symptoms, medications. It was reported that the following treatments improved the symptoms, XX epidural steroid injections, and physical therapy exercise regimen. The patient was reported to have had greater than XX weeks of conservative care prior to this current visit

included but not limited to physical therapy, medications and activity modifications without improvement. The patient rated the pain at time of assessment at its XX at XX/10, XX XX–10 present XX–XX/10 on the pain scale. The patient reported XX of the XX leg. The patient had a history of XX-XX5 XX XXXX. Past XX evaluation showed to be unremarkable with no history of any significant XX or XX problems. Upon examination of the motor testing it revealed well-developed and XX XX in the XX XX XX with no evidence of any XX of the XX-XX levels. There is no XX or XX that were noted, tone was XX and XX XX was normal as well as XX walking. Reflex inspection showed XX XX (XX): XX+/5. XX Achilles (XX): XX+/5. XX was XX XX. Examination of coordination revealed the patient's XX was XX with XX station. Examination of special XX reveals XX leg XX test while seated was XX XX and XX XX was XX present. Examination of the XX XX revealed point of XX tenderness of the XX XX XX XX. Range of motion was XX for XX in XX, extension, rotation and XX bending XX pain. MRI conducted on XXXX had the following assessment findings, there is evidence of XX XX XX of XX-XX right XX at XX-XX with suggestion of prior XX XX with no XX hardware. There is XX disc XX at XX-XX with a XX-based XX mm XX (XX versus XX contained XX). XX disc XX was noted at the XX-XX with XX XX–XX mm XX disc XX and XX XX XX and XX XX–XX mm containing XX compressing the XX XX and exiting XX XX roots. Moderate XX of the XX-XX XX joints with no evidence of a XX XX mm XX XX on the XX aspect of the XX XX joint was observed. There is mild to moderate XX XX and XX XX at XX-XX levels. There is also mild XX and XX at the XX-XX XX joints. The patient's treatment plan consisted of request for XX XX, XX XX ESI.

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

In this case Official Disability guidelines state that in regard to epidural steroid injections are recommended as a possible option for short-term treatment of XX pain (XX) with use in conjunction with active rehab efforts. Not recommended for XX XX or for nonspecific XX XX pain. The guidelines also stated that XX (due to XX nucleus XX, but not XX XX) must be documented. Objective findings on examination need to be present. XX must be corroborated by imaging studies and/or electrodiagnostic testing. However, in this case documentation provided for review in regard to objective findings were XX consistent with guidelines recommendations. It was reported that the patient has had a previous epidural steroid injection however there was no evidence of any XX XX or XX in pain as result of the injection.

Although the patient had reported XX XX pain with XX there is no corroborating documentation that would support the request at this time. Therefore, the request is not medically necessary and upheld.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, XX XX Chapter, Epidural steroid injections (ESIs), therapeutic