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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 Anesthesiology

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 who was diagnosed with pain in unspecified joint. (XX.XX). The additional diagnoses were XX XX pain (XX.XX), chronic XX XX (XX.XX), and long-term use of XX analgesics (XX.XX). The pain started on XXXX as a work-related injury. XXXX had XX XX injuries. XXXX XX injury was a XXXX injury with the onset of XX XX pain and the XX injury occurred when XXXX had a XXXX. XXXX. XXXX noted worsening of XX XX pain with the onset of XX XX pain with that injury.

XXXX was seen by XXXX on XXXX for XX XX pain. XXXX presented with XX XX XX pain worse than XX XX pain, left more than XX and XX XX XX pain. The intensity was described as XX. The pain was described as XX, XX, and XX. The pain was better with XX and XX exercises and XX with XX changes. The clinical presentation was consistent with XX-XX pain with XX XX XX pain overlying the XX XX of XX-XX and XX-XX, XX, and XX XX pain. The range of motion on XX, XX, and XX XX recreated the XX XX pain. The XX XX

examination revealed pain / tenderness in the XX XX regions (XX-XX and XX-XX) and limited range of motion with extension, XX, XX rotation, and XX XX XX.

An undated XX XX MRI showed XX XX disease at XX-XX.

Treatment to date consisted of medications (XXXX) and physical therapy without relief.

Per a utilization review determination letter dated XXXX and peer review dated XXXX by XXXX, the request for XX XX-XX XX XX XX XX XX (XX) 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. There was no clear documentation if the patient had exhausted conservative treatments and its objective responses. The actual MRI report was not submitted for review."

Per a utilization review determination letter and a peer review dated XXXX by XXXX, the requested service was denied. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not medically necessary. In light of this presenting issues and in the absence of pertinent extenuating circumstances that would require deviation from the guidelines, the request for XX XX XX-XX XX XX is not medically necessary as there was still no clear documentation if the patient had exhausted conservative treatments and its objective responses."

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

This patient presents with signs and symptoms that strongly support XX XX pain. A request has been submitted for a diagnostic XX XX XX at XX XX in the XX region. The procedure is ostensibly XX because XX injections are stated. Two utilization reviews were performed both of which accurately reviewed the patient's history in depth and medication usage. The ODG has several criteria that must be met prior to approval of these medical XX. I shall review the pertinent guidelines relative to this request and note whether they were fulfilled or not.

Failure of conservative treatment – both reviewers state that documentation of failure of conservative treatment was not provided. However, the provider's notes from XXXX clinic state that the patient had XX weeks of PT which were unsuccessful. The patient also pursues a home-based XX. So, this reviewer notes that this requirement of conservative therapy appears to have been met.

Other requirements such as a statement on the use of a XX-XX procedure, if the XX was effective, was stated in the patient's record - so this requirement is met. In addition, the patient will participate in stretching and XX after the XX – so the requirement of rehabilitation post-XX has been fulfilled. Finally, that a MRI report was not provided does not have relevance to this case, because the result would have minimal bearing on the diagnosis of XX. This patient has had XX XX injections in the past, which were largely XX. Given the documentation available, the requested service(s) is considered 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

Low Back Chapter

<u>Facet joint intra-articular injections (therapeutic blocks)</u>

Under study. Current evidence supporting this procedure is conflicting, and at this time, no more than one therapeutic intra-articular block is suggested. If this treatment is successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a XX XX XX XX and subsequent XX (if the XX XX XX is positive). If a therapeutic XX XX XX is undertaken, it is suggested that it be used in concert with other evidence-based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005)

See XX XX XX XX (injections); XX XX pain, signs and symptoms; XX XX XX XX; XX XX XX XX XX (therapeutic injections); and XX XX (diagnosis). See also the XX Chapter and Pain Chapter.

Criteria for use of therapeutic XX-XX and XX XX XX, are as follows:

1. No more than one therapeutic intra-articular block is recommended.

2. There should be no evidence of XX pain, XX XX, or previous XX.

3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a XX XX XX XX and subsequent XX (if the XX XX XX is positive).

4. No more than XX XX levels may be blocked at any one time.

5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to XX XX XX therapy.

In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-XX XX XX XX injections, they remain a popular treatment modality. XX-XX XX XX injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment XX in most evidence-based reviews, as their benefit remains controversial. The therapeutic XX XX XX described here are injections of a XX (combined with an XX agent) into the XX XX under XX guidance to provide temporary pain relief. (Dreyfuss, 2003) (Nelemans, 2000) (Carette, 1991) (Nelemans, 2001) (Slipman, 2003) (van Tulder, 2006) (Colorado, 2001) (ICSI, 2004) (Bogduk, 2005) (Resnick, 2005) (Airaksinen, 2006) An updated Cochrane review of injection therapies (XX, XX, XX XX) for XX XX pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal, 2009)

Systematic reviews endorsing XX XX-XX XX XX:

Pain Physician, 2005: In 2005, there were two positive systematic reviews published in Pain Physician that stated that the evidence was moderate for short-term and limited for long-term improvement using this intervention. (Boswell, 2005) (Boswell, 2005) These results were based, in part, on five observational studies. These non-controlled studies were confounded by variables such as lack of confirmation of diagnosis by dual blocks and recording of subjective pain relief, or with measures that fell under verbal rating and/or pain relief labels (measures that have been reported to have problems with validity). (Edwards, 2005)

Pain Physician, 2007: Pain Physician again published a systematic review on this subject in 2007 and added one additional randomized trial comparing XX-XX injections with XX XX to blocks with XX XX. The diagnosis of XX XX was made XX. (Fuchs, 2005) Two randomized trials were not included, in part because they failed to include controlled diagnostic blocks. These latter articles were negative toward the use of XX XX XX. (Lilius, 1989) (Marks, 1992) An observational non-controlled study with positive results was included that made the diagnosis of XX XX syndrome based on clinical assessment of "XX" XX pain, including evidence of an increase of pain in the morning and with excessive stress and exercise (no diagnostic blocks were performed). (Schulte, 2006) With the inclusion of these two articles, the conclusion was changed so that the evidence for XX XX-XX injections was "moderate" for both short-and long-term improvement of XX XX pain. (Boswell2, 2007)

Complications: These included suppression of the XX-XX-XX XX for up to 4 weeks due to steroids with resultant elevated XX levels for less than a week. (Ward, 2002) There have been rare cases of infection (XX XX, XX abscess and XX). (Cohen, 2007) Complications from needle placement include XX XX, XX XX XX, XX-XX and XX injection, spinal XX, XX trauma, XX, and XX XX. (Boswell2, 2007)

Single XX XX computed XX: (XX XX, XX scan): Not recommended, although recent research is promising. This technique is recommended based on the ability of XX bone XX to detect areas of increased function, depicting XX areas of inflammation as well as degenerative changes. Thirteen of 15 patients had a > 1 standard deviation pain score improvement at 1 month versus 7 of 32 patients with a negative or no scan. The benefit of the injection lasted for approximately 3 months and did not persist to 6 months. (Pneumaticos2, 2006)

☐ 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.