Clear Resolutions Inc.

An Independent Review Organization
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Description of the service or services in dispute:
XX XX epidural blocks under fluoroscopy, XXXX
XX- Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT)
XX - Fluoroscopic Guidance

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified 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 who sustained an XX injury on XXXX. XXXX had a history of XX pain radiating to the XX, a prior XX fusion in XXXX and XX, XX, XX XX, XX XX interbody fusion at XX-XX and XX-XX on XXXX. The diagnoses included XX XX with XX, XX at XX-XX, XX at XX-XX and XX-XX, XX XX XX, and XX XX XX.

On XXXX, XXXX was seen by XXXX for evaluation of XX XX pain. The pain was 6/10 with sitting, standing and with activity. XXXX noted XXXX walked XXXX five miles per day, climbed stairs, shopped, cooked, did housework and laundry, and worked 40 hours per week. XXXX weight was XXXX pounds and BMI was noted to be XXXX. On examination of the XX spine, there was tenderness over the XX XX-XX and XX-XX facets, increased pain on XX extension, trigger points at the XX and XX XX XX, positive XX straight leg raising test, XX reflex 1+ XX, and XX reflex -1 XX.

The treatment to date included medications (XXXX), physical therapy, and surgical intervention, which consisted of XX, XX, XX XX, XX XX interbody fusion (XX) right approach XX-XX, XX-XX performed on XXXX.

An x-ray of the XX spine dated XXXX showed persistent, slightly worsening instability at XX-XX; progressive instability at XX-XX; and stable minimal instability at XX-XX. A CT scan of the XX XX dated XXXX showed XX of interbody fusion, XX fixation and XX at XX-XX and XX-XX with XX across the disc spaces. There was no evidence of hardware complication. XX and facet XX were noted above the levels of fusion with moderate-to-severe XX XX XX at XX-XX and suspected moderate XX XX XX at XX-XX.

Per a utilization review decision letter dated XXXX, the request for XX medial branch blocks at XX-XX, XX-XX, and XX epidural steroid injection at XX-XX and XX-XX was denied and the request for a CT scan of the XX XX was certified by XXXX.

CT of the XX XX dated XXXX revealed at XX-XX XX XX from XX XX fixation XX partially obscures the soft tissue contents of the XX. Partially visualized XX XX, XX XX XX and XX XX with probable moderate XX XX XX and moderate XX and mild XX XX XX XX.

Per a utilization review decision letter dated XXXX, the request for XX XX-XX XX XX epidural blocks under fluoroscopy was denied by XXXX as not medically necessary or appropriate. Rationale: "This patient does not have XX XX. Motor, sensation, and reflexes are normal. As per the guidelines, when considering a XX epidural steroid injection, XX (due to XX XX 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. The medical records do not establish objective findings of XX on examination. Additionally, the medical records do not establish an imaging study that would corroborate any such XX. At the time of the prior review, the patient was approved for a XX XX CT scan. It does not appear that the patient has undergone the updated imaging study. The patient should undergo the previously approved imaging study prior to considering more invasive injection procedures."

Per a utilization review decision letter dated XXXX, the prior denial was upheld by XXXX as the services or treatments were not medically necessary. Rationale: "ODG-TWC discusses criteria for the use of epidural steroid injections in patients with XX, documented by objective findings on examination and corroborated by imaging studies and/or electrodiagnostic testing, after unresponsiveness to conservative treatment including exercises, physical methods, NSAIDs, muscle relaxants and neuropathic drugs. Injections should be performed using XX (XX) and injection of contrast for guidance. In this case, while diagnostic imaging demonstrates XX changes at XX-XX level with

evidence of XX XX XX at XX-XX, documentation submitted does not support clinical presentation consistent with XX. Absent correlation of abnormal imaging findings with current clinical presentation, the medical necessity of XX XX-XX XX epidural steroid injection under XX guidance is not established. Non-certification is recommended."

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

Based on the clinical information provided, the request for XX XX-XX XX XX epidural blocks under XX, XXXX; XX - Injection(s), anesthetic agent and/or steroid, XX epidural, with imaging guidance (fluoroscopy or CT); XX - XX Guidance is not recommended as medically necessary and previous denials are upheld. The initial request was non-certified noting that this patient does not have documented XX. Motor, sensation, and reflexes are normal. As per the guidelines, when considering a XX epidural steroid injection, XX (due to XX XX 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. The medical records do not establish objective findings of XX on examination. Additionally, the medical records do not establish an imaging study that would corroborate any such XX. At the time of the prior review, the patient was approved for a XX XX CT scan. It does not appear that the patient has undergone the updated imaging study. The patient should undergo the previously approved imaging study prior to considering more invasive injection procedures. The denial was upheld on appeal noting that ODG-XX discusses criteria for the use of epidural steroid injections in patients with XX, documented by objective findings on examination and corroborated by imaging studies and/or electrodiagnostic testing, after unresponsiveness to conservative treatment including exercises, physical methods, NSAIDs, muscle relaxants and neuropathic drugs. Injections should be performed using XX (XX XX) and injection of contrast for guidance. In this case, while diagnostic imaging demonstrates XX changes at XX-XX level with evidence of XX XX XX at XX-XX, documentation submitted does not support clinical presentation consistent with XX. Absent correlation of abnormal imaging findings with current clinical presentation, the medical necessity of XX XX-XX XX epidural steroid injection under XX guidance is not established. Non-certification is recommended. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines require documentation of XX on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active XX. There is no documentation of a sensory or motor deficit in a XX or XX XX. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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.