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IRO REVIEWER REPORT

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX joint injection (therapeutic with steroid) under fluoroscopy and monitored anethesia by an on-call 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 XXXX with a history of an XX claim from XXXX. The mechanism of injury was not detailed in the information provided for review. The current diagnoses were documented as XX, XX not elsewhere classified. In addition to surgery, the patient received treatment in the form of XX XX joint injections on XXXX. Anesthetic blockade produced complete relief of the patient's usual pain with the patient having positive steroid response with XX% relief of usual pain. The patient also underwent XX joint XX XX block injections on XXXX. On XXXX, the patient underwent diagnostic XX injection. Pre-injection pain level was a XX/10 on visual analog scale with post injection pain level at XX/10. The patient received an additional diagnostic XX injection at the XX XX-XX

facets on XXXX. The most recent examination was conducted on XXXX. The patient reported a chief complaint of XX leg XX, XX XX pain and XX XX leg pain. The patient's visual analog scale pain score was XX–XX/10 with the claim that symptoms were resolved since the last evaluation. XXXX complained of XX XX XX XX noted in the XX XX, thigh XX, and thigh XX as well as the calf XX and felt XX. The patient stated that "pain from the XX joints" was back. On physical examination, there was pinprick sensation decreased in the XX XX XX down the XX of the thigh and XX of the legs into the legs and shins and into the XX of the feet. Motor testing showed well-developed and symmetrical XX in the XX XX XX with no evidence of any weakness from XX through XX. There was no XX or XX noted and the patient had a XX tone. Reflexes were graded at XX+/5 for the XX XX region at XX and XX+/5 for the XX XX. The patient had an XX gait with XX straight leg raise testing. XXXX had decreased XX with point of maximum tenderness at the XX mid XX XX and XX XX XX XX. XXXX had limited range of motion in flexion due to pain and limited extension due to pain with extension greater than flexion. The physician claimed the patient received good relief from previous XX joint injections on XXXX. The patient's pain was interfering with activities of daily living and quality of life. Medications and activity modifications were no longer helping to control the pain. The physician claimed that due to the delicate nature of the procedure coupled with work in a sensitized/painful area around XX XX structures in a patient with XX, the patient would require anesthesia services for comfort and safety. The recommendation was for XX joint injection with fluoroscopy and monitored XX care by an on-call XX. The requested services were denied on XXXX with the rationale stating that XX joint injections are not recommended by current official disability guidelines in the absence of XX disease. A reconsideration was denied on XXXX with the rationale again stating that the therapeutic XX injections may be recommended on a case-by-case basis for inflammatory XX. XX should be confirmed with at least XX positive physical examination findings suggestive of the diagnosis, with a positive XX XX test, XX XX test, the side stress test as well as XX test and XX test. Although the patient reported good relief from a recent XX joint injection, the patient lacked physical examination findings of pain related to XX joint pathology to support the request.

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

According to the Official Disability Guidelines, diagnostic XX joint injections are not recommended, including XX XX-XX joint and XX XX diagnostic injection/blocks. Consideration can be made if the injection is required for one of the generally recommended indications for a XX XX. As for therapeutic injections, this is not recommended for noninflammatory XX pathology, based on insufficient evidence. In the case of this patient, the physician had requested both diagnostic and therapeutic

injections. Despite the claim that the patient reportedly had positive response to previous XX joint injections, the patient was not considered a candidate for receiving a repeated treatment at this time. There was a lack of information regarding a significant improvement in the patient's functionality following the previous injections. Additionally, the recent physical examination conducted on XXXX failed to provide any evidence of XX (XX) joint pathology in either region of the XX XX and XX area. Therefore, despite the indication that the patient may have necessitated monitored anesthesia care for this type of treatment, given the lack of evidence on physical examination to support XX joint pathology, with no reference to objective functional improvement from prior treatments and with the guidelines not recommending this form of treatment due to a lack of evidence pertaining to efficacy, the current service cannot be authorized at this time.

As such, in accordance with the previous denial, the request for XX XX diagnostic XX joint injection (see therapeutic with steroid) under fluoroscopy and monitored anesthesia by an on-call XX is not medically necessary and therefore 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, 15th Edition (web), 2018, XX and XX Chapter, XX injections, diagnostic.