P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 779-3287
Fax: (888) 350-0169
Email: manager@p-iro.com

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX Steroid Injection, XX with Fluoroscopy and Monitored Anesthesia 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 from XXXX. The mechanism of injury was detailed as a XXXX. The current diagnosis is listed as XX with radiculopathy. Past medical treatment has included physical therapy, activity modifications, medications, x-rays, myelograms, MRIs, XX laminectomy at XX-XX in XXXX, and XX studies. An MRI of the XX dated XXXX documented mild disc degeneration with mild diffuse disc bulge at XX-XX. There was severe bilateral hypertrophic XX with mild enhancing XX. There was XX. There was moderate XX narrowing, XX greater than XX. An orthopedic note dated XXXX documented the patient continued to complain of low back and XX lower extremity pain. The patient reported numbness in the foot and anterior tibial region. The patient reported weakness in the XX extremities and leg heaviness. Physical exam findings showed decreased sensation in the XX XX and XX dermatomes. There was normal muscle strength to XX extremities at 5/5. XX leg raise was positive on the XX. Moderate muscle spasm was noted to XX XX XX. There was tenderness to palpation of the XX XX XX. The note documented the patient suffered for greater than XX weeks from radicular symptoms. The note stated physical therapy, XX, and XX had failed to control symptoms. The treatment plan was for XX epidural steroid injection

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

The previous review dated XXXX denied the request for the XX epidural XX injection as the recent MRI failed to demonstrate any evidence of acute neural compressive findings that would support the need for an epidural procedure. Regarding the request for XX epidural XX injection, the patient presents with subjective complaints of XX pain with associated radicular symptoms. Physical exam findings are positive for XX and imaging correlates these findings with pathology at the specified level. The patient has tried and failed conservative therapy.

As such, the request for XX transforaminal epidural steroid injection, XX XX and XX with fluoroscopy and monitored anesthesia by XX is medically necessary and the previous decision is overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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