I-Resolutions Inc.

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

XX epidural steroid injection at XX-XX

XX Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, XX, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or XX, XX or XX

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Neurosurgeon

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)

XX. XX XX is a XX-year-old, XX-XX-XX XX who was injured on XX. The mechanism of the injury was described as a XX from a XX XX. There was a history of XX of XX. The diagnoses at the time were XX at XX-XX secondary to a jump facet at XX-XX on the XX and closed XX injury with a small amount of XX XX in the XX XX fissure region. XX ongoing diagnoses included XX of the XX region; XX; XX XX pain; pain in the XX XX; XX disc disorders with XX of the XX region; unspecified pain; XX XX or XX; disturbance of XX sensation; displacement of XX XX disc without XX; displacement of XX XX disc without myelopathy; XX of XX or XX XX disc; XX status; XX; XX; acquired XX; XX of the XX region; pain in XX XX; and closed fracture of XX XX XX.

On XX, XX. XX was evaluated by XX XX, XX for XX pain, XX pain, and XX XX pain. XX stated the pain two out of three in intensity at the time, and worse sometimes, but never improved. XX complained of XX and XX pain with radiation to the XX XX. XX sometimes felt a cold sensation on the XX XX. XX stated that XX was unable to XX XX strongly as XX used to; in fact, XX felt weakness in the XX XX XX, which was XX XX XX. XX complained of XX as XX was trying to XX things or XX at things, and XX felt weak and had a XX toward XX XX side. XX stated that this was a persistent problem and

seemed to be getting worse. XX also had pain in the XX, especially with a XX XX. XX also had pain to the XX XX with XX to the XX and into the XX on the XX aspect of the XX XX. XX noticed numbness and tingling. XX stated this seemed to be worse, but improved sometimes with certain positions. At nighttime, XX had XX XX XX pain. On examination, there was some decreased range of motion of the XX XX. XX XX sounds were diminished, but clear XX. XX were slightly weaker on the XX side at 4/5. XX ankle jerk reflexes were 1+. XX had equal XX, XX, XX, and extension, all 4/5. XX. XX documented XX. XX may have some progressive XX XX XX disease, which may be causing some of XX pain. XX ordered an MRI of the XX XX, and recommended an ESI at the XX-XX level, as epidural steroid injections had helped in the past.

An MRI of the XX XX was done on XX for XX XX. The study showed XX XX with anterior XX fusion between the XX margin of XX and the upper margin of XX. Posterior XX XX was also in place. There was a XX-mm XX disc XX at XX-XX with flattening of the XX XX and slight indentation of the XX surface. The XX was mildly narrowed in height. Mild narrowing of XX height with XX and mild XX disc XX at the XX-XX disc was noted. There was XX of disc height with disc XX and mild disc XX at XX-XX. An MRI of the XX XX from XX demonstrated XX XX disease at XX-XX and XX-XX with postsurgical changes from XX through XX.

The treatment to date included medications (XX with XX, XX, and XX) and surgery including anterior / posterior fusion (XX-XX) with XX instrumentation.

Per a utilization review decision letter dated XX and a peer review dated XX, the request for epidural steroid injection at XX-XX was denied by XX XX, XX. Rationale: "The patient has disc pathology on the latest MRI and XX XX weakness on MRI so an ESI could be considered. However, the last note of 3/19 states that ESIs have helped in the past but there are no details given to verify this to warrant repeating it nor could the office furnish this information, so the request is denied as there is no verification any prior XX ESI provided a therapeutic effect."

Per an adverse determination letter dated XX and peer review dated XX, the prior denial was upheld by XX XX, XX. Rationale: "The case was discussed with XX. XX, who confirmed that there was no recent imaging of the XX XX. XX stated that the indication for doing an ESI at XX·XX was generalized XX pain with XX, and that an Injection at that level would treat the levels above that level. In this case, based on the submitted medical records, there is no documentation of radiculopathy by physical examination with corroboration by imaging studies, or documentation of the results of prior ESIs. For these reasons, the prior determination is upheld and this request remains non-certified."

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 epidural steroid injection at XX-XX, XX Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, XX, XX, steroid, other solution), not including XX substances, including needle or catheter placement, XX epidural or XX, XX or XX is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines note that XX epidural steroid injections are not recommended based on recent evidence, given the serious risks of this procedure in the XX region, and the lack of quality evidence for sustained benefit. There is no specific information provided regarding prior XX epidural steroid injections. There are no updated imaging studies/electrodiagnostic results submitted for review. 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 XX XX 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 XX 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.