IRO Express Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 4/3/2019 1:17:15 PM CST

IRO Express Inc.

An Independent Review Organization
2131 N. Collins, #433409
Arlington, TX 76011
Phone: (682) 238-4976
Fax: (888) 519-5107
Email: reed@iroexpress.com

IRO REVIEWER REPORT

Date: 4/3/2019 1:17:15 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX sided XX and XX Transforaminal Epidural Steroid Injection

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]: XX. XX XX is a XX-year-old XX who was injured on XX. XX reported that XX had been involved in a work related incident. XX previously worked as a XX XX and was XX a XX XX XX in XX, by XX XX on a XX. XX reported doing it many times without any issues. In the one instance on XX, XX felt a pop in the XX and immediately had pain in the XX XX that radiated down the XX XX to XX XX. XX was diagnosed with radiculopathy, XX region (XX.XX). XX evaluated XX. XX on XX for XX XX and XX radicular XX pain. The symptoms were 60% localized to the XX XX XX XX and 40% localized to the XX XX. The symptoms in the XX were 60% on the XX side and 40% on the XX side. The pain was described as throbbing, stabbing, and sharp. It was worse with prolonged standing, walking, sitting, and bending forward and backward. The pain was improved with lying in the XX position and with oral medications. The

pain severity scores were ranging between 8-9/10 with an average pain score of 8.5/10 for the prior week. The pain was severe and functionally limiting. The pain had adversely affected XX ability to work, XX general activity level, and the ability to XX at XX. XX XX had been affected by the pain. XX was able to perform XX activities of daily living. XX reported being XX from XX XX because XX was XX XX XX to XX the XX associated with being a XX XX. On examination of the XX XX, the sensation was diminished to light touch in the XX XX XX; otherwise, sensation was intact to light touch in the XX XX-XX XX. Reflexes were difficult to obtain at XX XX due to the history of XX replacement. Reflexes were depressed at the XX XX tendon compared with the XX XX tendon. The manual muscle testing on XX XX flexion was 4/5 with pain limited testing, and XX XX was 4/5 XX. There was XX tenderness to palpation in the XX-XX segment. The active range of motion (AROM) was severely decreased with XX flexion of 30 degrees and extension of 10 degrees. The pain was worse with XX XX extension. There was a severely XX XX favoring the XX XX with decreased XX excursion. Straight XX raise was positive on the XX for radicular XX pain. The slump was positive on the XX for radicular XX pain. XX documented XX. XX had failed to improve with conservative management. An MRI of the XX XX dated XX revealed mild-to-moderate disc XX XX at XX-XX through XX-XX with mild complex XX XX XX and small posterior XX XX complexes at XX-XX through XX-XX with mild XX XX narrowing and XX narrowing at each of these levels. The treatment to date consisted of medications (XX, XX, XX, XX, XX, XX, and XX) and XX therapy without relief. XX had failed to improve with conservative management. Per the utilization review determination letter and review summary dated XX by XX, the request for XX-sided XX and XX transforaminal epidural steroid injection (XX, XX) was noncertified. Rationale: "Per evidence-based guidelines, ESI is not recommended for treatment of chronic XX XX pain in the absence of significant radicular symptoms and are recommended as a possible option for short-term treatment of radicular pain, which is defined as pain in dermatomal distribution with corroborative findings of radiculopathy with use in conjunction with active rehab efforts. In this case, the patient complained of XX XX and XX radicular XX pain. However, the sensation was intact to light touch in the XX XX-XX XX. There was also no actual imaging report submitted for review to validate the findings. The guidelines further stated that transforaminal ESI is not significantly better at providing pain relief or functional improvement. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, ESI is not recommended for treatment of chronic XX XX pain in the absence of significant radicular symptoms and are recommended as a possible option for short-term treatment of radicular pain which is defined as pain in XX distribution with corroborative findings of radiculopathy with use in conjunction with active rehab efforts. In this case, the patient complained of XX XX and XX radicular XX pain. However, the sensation was intact to light touch in the bilateral XX-XX XX. There was also no actual imaging report submitted for review to validate the findings. The guidelines further stated that transforaminal ESI is not significantly better at providing pain relief or functional improvement." Per a reconsideration review determination letter and review summary dated XX by XX, the request for XX sided XX and XX transforaminal epidural steroid injection was denied. Rationale: "Per evidence-based guidelines, ESI is recommended as a possible option for short-term treatment of radicular pain defined as pain in dermatomal distribution with corroborative findings of radiculopathy with use in conjunction with active rehab efforts. In this case, XX complained of XX XX and XX radicular XX pain. Straight XX raise was positive on the XX for radicular XX pain. The treatment plan was a XX-sided transforaminal ESI; however, the presence of significant radicular symptoms in a XX and / or XX distribution that correlates with XX and XX was not clearly established in the most recent office visit to support the request. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The treatment plan was a XX-sided transforaminal ESI; however, the presence of significant radicular symptoms in a XX and / or XX distribution that correlates with XX and XX was not clearly established in the most recent office visit to support the request."

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

Official Disability Guidelines discusses indications for epidural injections, which are generally indicated in situations where there are symptoms, exam findings, and diagnostic studies which confirm the presence of a radiculopathy at a particular level. Prior reviews have noted that it is not clear that this patient has collaboration of symptoms and exam findings to support the radiographic finding in this case. Current office notes clearly indicate sensation diminished in the XX XX XX, as well as reduced strength at 4/5 in XX XX flexion, and most notably in XX XX flexion XX. The patient was noted to have a XX XX XX and positive straight XX raising on the XX. These findings appear to be consistent with the radiographic findings of foraminal narrowing at multiple levels, but particularly at XX-XX.
The patient has failed other first-line treatment and there are clear neurological findings on exam, the request is medically necessary and should be overturned.

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 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 & 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

Criteria for the use of Epidural steroid injections