C-IRO Inc.

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

XX epidural steroid injection (XX) at XX-XX with twilight sedation and fluoroscopic guidance.
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 (XX)
XX: Injection, XX XX, XX mg
XX: Injection, XX XX, per XX mg
XX: Fluoroscopic Guidance

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

Board Certified Pain Management Physician

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 who was injured on XX. The biomechanics of the injury was not available in the medical records. XX was diagnosed with XX XX pain (XX).

XX. XX was seen by XX XX, XX / XX XX, XX on XX for a follow-up visit and secondary complaints of XX XX pain. The pain was described as constant, sharp, aching, and shooting. It radiated into the XX XX and throughout the XX XX XX, starting at the XX and shooting up the XX XX. It was rated at 6/10. The symptoms were exacerbated by standing, walking, and activity. They were improved with massage and medications. The pain was worse in the morning. On examination, the stance revealed weightbearing on the XX. The XX jerk reflexes were diminished on the XX. The XX / XX / XX XX sensations were diminished at the XX XX-XX and XX-XX. On XX / XX examination, standing maneuvers revealed painful flexion and extension. Straight XX raise test was positive on the XX at 30 degrees. There was tenderness at the XX XX-XX level with palpation. XX had tenderness over the XX XX XX. XX's test was positive XX. Examination of the XX XX showed tenderness to palpation over the XX XX. The range of motion including XX flexion was painful on the XX. XX had weakness of the XX XX XX. The plan was to proceed with XX at XX-XX.

Electromyography (EMG) / nerve conduction study (NCV) was performed on XX for constant severe XX XX pain with electrical shooting pain, numbness, and tingling radiating to the XX XX XX. The study showed no electrodiagnostic evidence of XX radiculopathy, XX XX, XX compression neuropathy of the XX XX, peripheral neuropathy or myopathy. An MRI of the XX XX dated XX showed slight posterior XX XX at the XX-XX level with no XX XX and moderate previous compression XX involving the superior endplate of the XX XX body.

The treatment to date included medications {XX, XX, and XX (helpful)} and massage (helpful).

Per a utilization review decision letter and peer review dated XX, the request for XX epidural steroid injection (XX) at XX-XX was denied by XX XX, XX. Rationale: "Official Disability Guidelines (ODG) recommends epidural steroid injections as a possible option for short-term treatment of radicular pain (defined as pain in XX distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. They are not recommended for XX ZZ or for nonspecific XX XX pain. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. Within the associated medical file, there is documentation of subjective findings of XX XX pain. The patient reports the pain radiates into the XX XX and the XX XX XX. The pain is rated as a 6/10. The patient reports the symptoms have improved with massage and medications. Objective findings include a diminished XX XX jerk. Diminished light touch on the XX XX-XX and XX-XX is noted. There is a positive straight XX raise test on the XX. There is tenderness to palpation on the XX XX and weakness in the XX XX XX. However, there is no official MRI report available for review demonstrating XX XX or nerve root XX at XX-XX indicative of XX or EMG report noting XX at XX-XX. Moreover, there is no clear documentation of failure to respond to XX therapy. Therefore, I am recommending non-certifying the request for XX XX-XX (one injection)."

Per an adverse determination letter and peer review dated XX, the prior denial was upheld by XX XX, XX. Rationale: "Regarding XX epidural steroid injection criteria, per ODG, "Radiculopathy must be corroborated by imaging studies and / or electrodiagnostic testing." In this case, XX MRI did not reveal nerve root impingement. EMG was negative for radiculopathy. A successful peer-to-peer call with XX XX, XX was made at XX. The details of the request were discussed. Per the discussion, the MRI findings and EMG findings were acknowledged. XX said that the XX epidural steroid injection would be diagnostic, but the MRI does not show significant pathology and it is unclear how a diagnostic injection would influence the treatment plan. There are no documented extenuating circumstances to support an exception to the guidelines. There was a previous adverse determination dated XX wherein the request for XX epidural steroid injection at XX to XX was non-certified. The requested reconsideration XX XX-XX, XX, XX, XX, XX, #1 is not shown to be medically necessary and the previous determination of noncertification is upheld."

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 (XX) at XX-XX with twilight sedation and fluoroscopic guidance, XX: Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, XX, XX, steroid, other solution), not including neurolytic substances, including needle or catheter placement, XX epidural or XX, XX or XX (XX), XX: Injection, XX XX, XX mg, XX: Injection, XX XX, per XX mg, XX: Fluoroscopic Guidance 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 require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The submitted XX MRI fails to document significant neurocompressive pathology. EMG/NCV dated XX revealed there is no electrodiagnostic evidence of XX radiculopathy. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no documentation of completion of a course of XX therapy. 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 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.