True Decisions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 1/29/2019 3:03:22 PM CST

True Decisions Inc.

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IRO REVIEWER REPORT

Date: 1/29/2019 3:03:22 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX XX-XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Pain Medicine, Physical Medicine & Rehab

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. The biomechanics of the injury was not available in the medical records. XX was diagnosed with XX (XX.XX) XX. XX was seen by XX on XX and XX for XX XX pain. On XX, XX presented with worsening of XX XX pain with XX XX XX. The pain was described as XX, XX, XX, XX, and XX into the XX XX, rated at XX/10. The symptoms were associated with daily activity and walking. The modifying factors included rest, change in position, and medication. XX did present approximately one week prior with XX inability to ambulate secondary to severe pain. On examination, XX XX was noted. There was XX to palpation with XX XX pain with XX XX XX. The XX pain was getting progressively worse with weakness noted down the XX XX extremity. XX to XX XX with exacerbation of the overall pain. XX had limited range of motion and weakness with new neurological deficits including XX and weakness on the XX XX XX. XX examination revealed abnormal XX, sensation, and strength. XX XX reflexes were XX-reflexive. There was decreased XX sensation to the XX XX XX. Also XX and weakness were noted to the XX XX XX. Overall no muscle wasting was noted, but significant XX deficits were noted. XX recommended XX XX at XX-XX

and XX-XX on the XX side. XX commented that XX. XX was getting progressively worse secondary to withholding treatment. XX was also becoming extremely XX secondary to the pain and had XX walking and was using a XX. On XX, XX. XX continued to have XX XX pain. The pain was described as intermittent, XX, XX, XX and XX into the XX extremities to the XX XX to XX, rated at XX/10. The XX were XX. XX had to visit emergency room XX times in XX XX as the pain had become debilitating. The daily activities, standing, and walking were affected due to the pain. XX was unable to return to work secondary to the pain. Examination remained essentially unchanged as compared to prior visit with addition of XX was XX XX with exacerbation of the overall pain. XX had severe shooting and intractable pain secondary to an acute exacerbation of overall pain from is work related injury. There was weakness on XX XX. The XX pain did travel into the XX XX along the XX-XX and XX-XX XX distribution. An XX of the XX XX dated XX revealed XX and XX XX with diffuse XX XX XX, age-related XX XX and grade 1 XX XX on XX. There was XX space XX at XX-XX and XX-XX. Mild XX XX XX was identified at XX-XX with a XX XX and XX XX changes. There was moderate-to-severe XX XX XX at XX-XX with a XX XX, XX XX changes, and minor XX and moderate XX XX XX narrowing. There was severe XX XX XX at XX-XX with the XX, XX XX, XX XX changes, and XX XX XX XX narrowing and impingement of the exiting XX XX XX root. The treatment to date included medications (XX, XX-XX, XX, and XX), physical therapy, XX XX on XX, XX, XX, XX, XX, and XX (helpful). Per a utilization review peer reviewer's response letter dated XX, the request for XX XX XX (XX) (XX, XX, XX) was non-certified by XX. Rationale: "There were no documentation of percentage of relief nor at length of time or relief from prior XX. Official Disability Guidelines (ODG) Online Edition, XX XX Chapter, Updated XX, XX (XX), therapeutics does not support this request. Based on the documentation provided and per ODG guidelines, the requested XX XX XX at XX-XX XX XX-XX-XX is not medically necessary. Though the patient has a history of XX XX pain with XX symptoms, subjectively and objectively, there were no documentation of percentage of relief nor at length of time or relief from prior XX. Per the ODG guidelines, "XX." Per a utilization review peer reviewer's response letter dated XX, the request for XX XX XX XX injection at XX-XX was non-certified by XX. Rationale: "XX "XX (XX), therapeutic Recommended as a possible option for short-term treatment of XX pain (defined as pain in XX distribution with corroborative findings of XX) with use in conjunction with active rehabilitation effort. Not recommended for XX XX or for nonspecific XX XX pain. See specific criteria use below. XX." The request was denied on XX, whereby the request for XX XX XX XX, XX, XX was not certified. The reviewer noted that there was no documentation of percentage of This is a request for an appeal. In this case, the guidelines exceeded due to the number of levels requested. Therefore, the request for XX XX XX XX-XX XX XX, XX, XX is not medically necessary and 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 (XX) at XX-XX XX - Injection(s), anesthetic agent and/or XX, XX, with XX (XX); XX or XX, single level, XX - Injection(s), anesthetic agent and/or XX, XX XX, with XX (XX); XX or XX, each additional level (List separately in addition to code for primary procedure) XX is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review peer reviewer's response letter dated XX, the request for XX XX (XX) (XX, XX, XX) was non-certified by XX. Rationale: "XX. As such the request is not certified." Per a utilization review peer reviewer's response letter dated XX, the request for XX XX at XX-XX was non-certified by XX. Rationale: "XX The request was denied on XX, whereby the request for XX injection XX XX, XX, XX was not certified. The reviewer noted that there was no documentation of percentage of this is a request for an appeal. In this case, the guidelines exceeded due to the number of levels requested. Therefore, the request for XX XX XX XX-XX XX XX, XX, XX is not medically necessary and non-certified." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines require documentation of XX on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to document a sensory or motor deficit in a XX or XX distribution. The patient's objective functional response to prior XX is not documented to establish efficacy of treatment. Current evidence based guidelines require documentation of

at least XX-XX% pain relief for at least XX XX. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. Therefore, medical necessity is not established in accordance with current evidence based guidelines.
Given the documentation available, the requested service(s) is considered not medically necessary and the request is 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 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