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IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 1) Diagnostic XX XX steroid injection XX/XX on the XX times one and 2) XX XX/XX level XX XX of the XX XX XX times one

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]: Patient is a XX year old XX who sustained an injury on XX. The patient was trying to XX an XX and XX on XX XX. The patient was XX on the XX and XX. The patient was diagnosed with a XX of XX of the XX XX, initial encounter and XX of XX, XX and XX of XX XX, initial encounter. Provider is requesting 1) Diagnostic XX XX steroid injection XX/XX on the XX times one and 2) XX XX XX XX/XX level XX XX of the XX XX XX times one.

XX – Status Report-XX: Description of Injury: Pt states XX was trying to XX an XX and XX on XX XX. Indicates XX was XX on the XX and XX. Subjective Complaints: Pain level 7/10. XX XX: Pt presents for initial visit. Decreased ROM is reported in XX. No radiating pain; no numbness or tingling reported. Pain increases with inspiration. XX XX: Decreased ROM is reported in XX. Pain level 4/10. No pain radiating to XX. No numbness or tingling in XX extremities is reported. No loss of XX/XX control. X-Rays: XX XX: XX-XX-XX, x-rays were negative for fracture or dislocation. XX XX: XX XX (XX, XX, XX) x-rays were negative for fracture or dislocation. Diagnosis: XX of XX of XX XX, initial encounter XX.XX; XX of XX, XX and XX of XX XX, initial encounter XX.XX; Unspecified injury of XX, initial encounter; Unspecified injury of XX, initial encounter. Recommendations: 1) PT eval and treat on XX of XX XX; strain of XX, XX and tendon of XX XX for essential functions and functional improvement. 2) Med: XX XX and XX XX. 3) Injury/med precautions. 4) F/u sooner if worsening symptoms.

XX – Status Report-XX: Description of Injury: Pt states XX was trying to XX an XX and fell on XX XX. Indicates XX was XX on the XX and XX. Subjective Complaints: Pt is here for f/u, states XX XX XX is fine with no pain, but XX XX still hurts because this morning XX XX an XX from XX XX XX-XX and caused a flare-up. XX XX: Pt states that overall the symptoms have remained the same. XX pain level is 7/10. ROM remained the same. No radiating pain. No numbness or tingling. XX XX: Pt states that overall the symptoms have resolved. No pain. ROM is normal. No radiating pain. No numbness and tingling. No XX extremity weakness. No XX of XX/XX XX. Diagnosis: XX of XX of XX XX, initial encounter XX.XX; XX of XX, XX and XX of XX XX, initial encounter XX.XX; Unspecified injury of XX, initial encounter; Unspecified injury of XX, initial encounter. Recommendations: 1) Continue PT. 2) Medication: XX XX po q XX hrs prn breakthrough pain. 3) Injury/meds precautions. 4) F/u sooner if symptoms worsen.

XX – Status Report-XX: Description of Injury: Pt states XX was trying to XX an XX and XX on XX XX. Indicates XX was XX on the XX and XX. Subjective Complaints: Pt is here for f/u, states XX pain level is 10/10, not able to sleep. XX XX: Pt states that overall the symptoms have increased. Pain level of 10/10. ROM remained the same. No radiating pain. No numbness or tingling. Pain increases with inspiration. XX XX: Pt states that overall the symptoms have increased. Pain increased; pain level of 10. ROM is decreased. No radiating pain. Numbness and tingling c/o numbness with XX XX. No XX extremity weakness. No XX of XX/XX XX. Diagnosis: XX of XX of XX XX, initial encounter XX.XX; XX of XX, XX and tendon of XX XX, initial encounter XX.XX; Unspecified injury of XX, initial encounter; Unspecified injury of XX, initial encounter. Recommendations: 1) No PT at this time. 2) Med: XX as prescribed. 3) Injury precautions. 4) Will get MRI for further eval due to worsening symptoms and make further recommendations accordingly. 5) F/u sooner if symptoms worsen. 6) Diagnostic imaging/Testing: MRI of XX XX without contrast and XX XX without contrast. Reason for early MRI: Pt c/o worsening symptoms.

XX – Status Report-XX: Description of Injury: Pt states XX was trying to XX an XX and XX on XX XX. Indicates XX was XX on the XX and XX. Subjective Complaints: Pt is here for f/u, 8/10 pain level. Pt had appt for MRI on 6/11/18 only had the XX done pt has the cd, states the XX part was rescheduled due to equipment issues. XX XX: Pt states that overall the symptoms have decreased. XX reports a pain level of 8. ROM remained the same. No radiating pain. No numbness and tingling. Pain increases with inspiration remained the same. XX XX: Pt states that overall the symptoms have decreased. Pain decreased. XX reports a pain level of 8. ROM remained the same. No radiating pain. Numbness and tingling decreased c/o numbness with XX XX. No XX extremity weakness. No XX of XX/XX XX. Diagnosis: XX of XX of XX XX, initial encounter XX.XX; XX of XX, XX and tendon of XX XX, initial encounter XX.XX; Unspecified injury of XX, initial encounter; Unspecified injury of XX, initial encounter. Recommendations: 1) No PT at this time. 2) Continue med: XX as prescribed. 3) Injury precautions. 4) Pt to call and schedule the MRI and will review report with pt next visit. 5) Pt indicates XX will continue exercises that help XX at home and will consider PT after MRI is done. 6) F/u sooner if worsening symptoms.

XX – Radiology Report-XX: MRI XX XX. Clinical History: XX year old XX with XX pain and history of an injury related to an XX in XX. Findings: XX structures: There is a subtle XX XX at XX. No XX XX XX XX were seen. The XX XX pattern is unremarkable. No significant XX XX is appreciated. XX XX XX/XX XX/XX XX: The visualized aspects of the XX XX XX and XX XX appears unremarkable and there is trace normal appearance and positioning. The XX XX and XX XX were grossly negative. XX XX XX/additional findings: No significant XX XX XX XX or significant additional abnormalities are identified. Impression: 1) Moderate XX XX XX at XX-XX as described above in greater detail with resulting moderate compression of the XX XX XX XX. Correlation for XX XX extremity XX and nerve conduction study may also be beneficial. 2) Subtle XX XX XX of XX. Note: The chronicity of these findings is indeterminate unless specifically mentioned above.

XX – Radiology Report-XX: MRI XX XX. Clinical History: XX year old XX with XX pain and history of XX. Impression: 1) XX XX XX measuring approximately XX is discovered at XX-XX creating mild XX XX XX XX without XX impingement. 2) Subtle XX XX of XX. Note: The chronicity of these findings is indeterminate unless described above.

XX – XX Therapy Re-Evaluation-XX: Medical Dx: Sprain of XX of XX XX, subsequent encounter XX.XX; Sprain of XX, XX and XX of XX XX, subsequent encounter XX.XX. Comorbidities: XX: May impact participation in therapy if elevated. Current pain status: XX. 8-9/10 pain that keeps XX up or wakes XX up at night. Examination: Neuromuscular: Pt came to therapy today with slight XX XX. Pt can perform sit to stand without UE support with no visible sign of distress. Pt

demonstrates tendency to flex in XX XX with XX XX and struggles to XX in XX and XX even with cues to correct movement mechanics. Pt reports tenderness and sharp pain at XX junction. Posture: Forward XX, rounded XX; increased XX XX. Activity limitations: XX. Participation restrictions: Unable to perform full duty at work. Plan of care XX x XX wks. Current Procedural Terminology: XX Manual Therapy Techniques; XX Therapeutic Exercises; XX Neuromuscular Reeducation; XX Therapeutic Activities; XX Self-Care/Home Management Training. Short Term Goals: XX weeks: Goal Partially Met; Increase XX to XX and pain free to ensure abilities to XX. Objective Findings: Pt demonstrates limited mobility by pain. Long Term Goals: XX weeks: Goal Partially Met: Pt will XX XX XX and XX for XX feet x XX reps demonstrating proper body mechanics and 0/10 pain to ensure XX and XX at work. Objective Findings: Pt demonstrates functional ability to perform this exercise- XX demonstrates poor XX mechanics and reports pain and difficulty with XX. Goal Partially Met: Pt will XX/XX XX to XX x XX reps demonstrating proper body mechanics and 0/10 pain to ensure XX at work. Objective Findings: Pt demonstrates functional ability to perform this activity but reports pain and symptoms with activity and requires extra time to perform. The above plan of care is intended to achieve optimal improvement, independence with a home exercise program, pre-injury status.

XX – XX Therapy Report-XX, DPT: Medical Dx: Sprain of XX of XX XX, subsequent encounter XX.XX; Sprain of XX, XX and tendon of XX XX, subsequent encounter XX.XX. Subjective: Pt states that XX was in so much pain yesterday that XX needed a new medication. XX reports the prior several days that XX was doing ok just really busy. XX reports that XX is tired today. Pt states the day XX was in pain that XX did not do XX exercises, XX only took medication and rested to help with XX pain. XX Therapeutic Exercises XX mins. XX Neuromuscular Re-Education XX mins. Assessment: Pt continues to report no change in symptoms, show no carry over with mechanics training and XX XX. Pt is able to complete all tasks and carry on pleasant conversation demonstrating no limitations. Given no change in pain pt may be more appropriate for additional MD evaluation and treatment. Plan: Continue therapy for reducing impairments and improving functional performance, intervention emphasis on achieving functional goals, body mechanics training to prevent exacerbation of injury, prevention of functional regression and instruction in a progressive HEP.

XX – XX Therapy Report-XX, DPT: Medical Dx: Sprain of XX of XX XX, subsequent encounter XX.XX; Sprain of XX, XX and tendon of XX XX, subsequent encounter XX.XX. Subjective: Pt states that when XX went home yesterday after therapy XX kept moving for a XX instead of laying down. XX reports that when XX woke up this morning that XX XX “seized up.” XX states that XX hasn’t moved much since it seized this morning. Pt states that XX pain is starting to wear on XX that XX “XX. Therapeutic Program/Interventions: XX Therapeutic Exercises XX mins. XX Neuromuscular Reeducation XX mins. Assessment: Pt required increased encouragement to participate today. XX had increased symptoms with XX XX and with XX exercises. Pt is capable of finishing all interventions but pain remains. Pt continues to exhibit no change in overall symptoms. XX may benefit from further evaluation and alternative treatment due to no change in patient status. Plan: Continue therapy for reducing impairments and improving functional performance, essential function performance, intervention emphasis on achieving functional goals, body mechanics training to prevent exacerbation of injury, prevention of functional regression and instruction in a progressive HEP, increasing weight-bearing activities and integrating truck posture movement during functional activities.

XX – Follow up Evaluation-XX: Description of Injury: Pt states XX was trying to XX an XX and XX on XX XX. Indicates XX was XX on the XX and XX. Subjective complaints: Pt is here for a follow up. XX states XX is still in pain, feels like no change. States XX went to the XX last XX because of pain and weakness, had blood work done and told everything was fine. Had IV fluid and meds prescribed. XX XX: Pt states that overall the symptoms have remained the same. Pt reports a pain level of 7. ROM remained the same. No radiating pain, no numbness or tingling of the XX. Pain increases with inspiration remained the same. XX XX: Pt states that overall the symptoms have remained the same. Pain increased. XX reports a pain level of 6. ROM remained the same. No radiating pain. Increased numbness and tingling of both XX. Diagnosis: Sprain of XX of XX XX, subsequent encounter XX.XX; sprain of XX, XX and XX of lower XX, subsequent encounter XX.XX; unspecified injury of XX, subsequent encounter XX.XX; unspecified injury of XX, subsequent encounter XX.XX. Recommendations: 1) No PT at this time; 2) Meds: per pain management; 3) Pt was advised to f/u with XX PCP for non-work related positive review of symptoms and/or positive past medical hx; 4) Injury precautions; 5) Pt c/o pain and wants something stronger for pain, will refer to pain management for med management; 7) F/u sooner if worsening symptoms; 8) Referral to pain management. Next appt date: XX.

XX – Physician Notes-XX: Chief complaint: XX XX pain and XX XX pain. MRI LS XX positive for XX XX at XX/XX. Present

Illness: Able to stand for XX than XX minutes. Able to sit for XX than XX minutes. Pain level now 7-9/10. Pain level at best and worst is 7-9/10. Pain feels like constant soreness, aching pain, numbness, burning, throbbing and stiffness. Hot baths and XX XX helps with pain. The pain onset was associated with a specific event work-related injury. XX was XX by an XX. Treatments tried include XX therapy; XX sessions with minimal to no help. The pain is made worse by standing, sitting and walking. The patient is not working. Assessment: Sprain of XX of XX XX, initial encounter XX.XX; Sprain of XX, XX and XX of XX XX, initial encounter XX.XX. Plan: Per ODG guidelines, diagnostic XX is requested. Criteria for neurological deficits, imaging consistency and clinical findings are met. XX/XX level on the XX. XX XX XX of the XX XX XX XX XX/XX XX times one. FCE and psychological evaluation for a chronic pain program. Follow up at this clinic as needed. For procedure; follow up with referring physician.

XX – URA Determination-XX: XX has been asked to review the services below for medical necessity only. We decided that the services or treatments described below are not medically necessary or appropriate. This means that we do not approve these services or treatment. This is not a notice of coverage or guarantee of payment. Requested: Diagnostic XX XX XX/XX on the XX x1 – Decision: Denied. Requested: XX XX XX XX/XX level XX XX XX x1 – Decision: Denied. Based on the submitted records, the patient appears to have both XX XX pain and XX XX pain with XX symptoms to the XX XX. Past treatments include medications and a course of PT, without resolution of symptoms. Objective exam was notable for pain in the XX XX with XX rotation and pain in the XX XX-XX XX XX XX. XX examination was for poor XX XX, positive XX XX, and sensory deficits in the XX XX-XX XX. An MRI report shows XX XX XX XX at XX-XX along with a large XX XX at the XX-XX level impinging on the XX XX XX XX. The treating providers are now requesting to perform a XX XX epidural and a XX-XX XX XX for diagnostic purposes. ODG XX XX states the following regarding diagnostic XX epidural injections: 1) To determine the level of XX pain, in cases where diagnostic imaging is ambiguous, including the examples below: 2) To help to evaluate a radicular pain generator when physical signs and symptoms differ from that found on imaging studies. In this case, the patient appears to have ongoing XX symptoms with objective findings of XX on exam in the XX XX-XX XX along with signs of facet mediated pain in the XX XX-XX region. Past conservative treatments have failed. Given that ODG supports XX epidural injections for diagnostic purposes when the imaging studies and the physical signs differ, this request for a XX XX epidural can be considered appropriate. In regards to the XX XX, the submitted documents make no mention of whether this procedure will be done for diagnostic or therapeutic purposes. Additionally, if for diagnostic purposes, ODG states that there should be a plan in place to proceed with XX, but no mention of XX XX is noted in the submitted records. As such, and since a peer-to-peer discussion must take place to modify a request, this request for both a XX epidural and XX XX is not appropriate or medically necessary.

XX – Physician Notes-XX: Chief complaint: Pt complains of XX XX pain. The pt complains of XX XX pain. MRI LS XX positive for XX XX at XX-XX. Present Illness: Able to stand for XX than XX mins; able to sit for XX than XX mins; able to walk for XX than XX mins. Pain level now 7-9/10. Pain at worst 7-9/10; pain at best 7-9/10. Pain feels like constant soreness, aching pain, numbness, burning, throbbing and stiffness. XX XX and XX XX denied in spite of meeting ODG. No changes in review of systems since the most recent visit. Assessment: Diagnosis: Strain of XX, XX and tendon of XX XX, initial encounter; sprain of XX of XX XX, initial encounter. Plan: Other treatment: Appeal denied. Follow up at this clinic in XX for re-evaluation.

XX – URA Re-Determination-XX: Appeal Denied, this is the second request and denied by a different physician. Any further requests should be submitted through the appeal process with IRO. XX has been asked to review the services below for medical necessity only. This is not a notice of coverage or guarantee of payment. This is not an approval for a provider that is not in the patient's network to perform services. If a provider is not in the network, the provider must have additional Out of Network approval from the network or payment may be denied. Requested: Diagnostic XX XX XX/XX on the XX x1 – Decision: Denied. Requested: XX XX XX/XX level XX x1 – Decision: Denied.

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

The request for XX sided XX-XX XX XX steroid injection (XX) and XX XX XX-XX is denied.

This patient is a XX year-old XX who was injured at work on XX. XX was XX an XX when XX XX on XX XX. XX has pain in the XX and XX XX. The record indicates that XX has XX symptoms in the XX XX. XX has completed a course of XX therapy and medication. The MRI of the XX XX confirms XX at XX-XX with compression of the XX XX XX. The XX XX MRI confirms a XX-sided XX at XX-XX. The treating physician has recommended a XX XX-XX XX XX and XX XX XX-XX.

The Official Disability Guidelines (ODG) supports diagnostic XX in patients with XX with inconclusive imaging studies. XX are not recommended by the ODG. These XX can be considered in patients with pain associated with XX.

1. The MRI confirms XX of the XX XX XX, which does not correlate with the XX sided symptoms. XX has no XX identified on the XX side, to support a XX-sided XX. For this patient, electrodiagnostic testing (EMG-NC) should be considered prior to a diagnostic XX.
2. The XX MRI does not document XX. XX in the XX XX is unusual, especially in a XX patient.

The recommended injections are not medically necessary.

Per ODG for XX XX

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

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**