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IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX XX with fluoroscopy & monitored anesthesia by on call CRNA.

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 whose is status post XX fusion AP – XX-XX in XX. XX currently having XX XX pain and the provider is requesting a XX XX XX with fluoroscopy & monitored anesthesia by on call CRNA.

XX – MRI Report-G. XX: MRI XX-XX w/o contrast. Diagnosis: 1) At XX-XX there is no XX or XX. No XX or XX. 2) At XX-XX, XX or XX. Mild XX. Mild XX. Mild XX. 3) At XX-XX, moderate XX. There is an approximately XXcm superiorly migrated posterior XX flattens the XX. Marked XX. Moderate XX. Moderate to marked XX XX secondary to XX. Milder to moderate XX. 4) At XX-XX, patient status post anterior XX and XX. Solid interbody fusion. No XX. 5) At XX-XX, patient is status post anterior XX and XX. Solid interbody fusion. No XX. The XX XX are within normal limits in signal.

XX – XX Injection Report-XX: Pre-op diagnosis: Degenerative XX XX disease. Post-op diagnosis: XX XX XX. Procedures performed: 1) Fluoroscopically guided needle localization of the XX XX XX nerve(s) with transforaminal epidural steroid injection(s). 2) Transforaminal Epidurogram(s) at XX XX. Findings: Poor filling XX XX. Due to previous XX surgery a transforaminal epidural was done concordant provocation XX XX XX. Pain relief – 100%.

XX – Physician Report-XX-BC: Chief Complaint: XX XX pain. XX XX follow up: The pt complains of XX XX XX pain. Current VAS 2-5/10. The symptoms are better since the last eval. The pt also complains of XX XX extremity pain in the anterior XX region. Current VAS 3-4/10. The symptoms are somewhat worse since last eval. XX has a constant XX pain with is 3-7/10 but is better than when XX first came into the office. XX XX are better and does not get the shooting pain down XX XX. XX has pain with rising from a seated position and with standing. No new diagnostic testing. Current treatment for the present complaint(s) includes the following: medications and transforaminal steroid injections. The current treatment is providing little relief of current symptoms. The patient reports weakness in the XX and XX. Impression/Diagnostic: 1) Post-op XX XX: s/p AP XX fusion XX-XX (XX.XX); 2) Disc disruption w/o XX XX: XX.XX): Central XX-XX (XX.XX); 3) XX XX (ICD-9-CM:XX): marked XX XX-XX and moderate XX XX-XX (XX)(XX); 4) XX XX XX with XX/XX-marked: XX-XX (XX); 5) XX XX (XX) (XX/XX): XX-XX XX (XX); 6) XX disc displacement with radiculopathy (XX) (XX)-XX XX-XX; 7) Final diagnosis pending further evaluation. Recommendations: XX XX: XX selective nerve root block/transforaminal ESI: XX XX (CPT-4: XX single) (CPT-4: XX additional). Epidurogram interpretation (CPT-4: XX) or fluoroscopy (CPT-4:XX). Diagnostic XX facet injections [as part of potential RFA workup]: XX XX-4 (CPT-4: XX single). XX XX epidural steroid injection XX-4: (CPT-4: XX). Epidurogram interpretation (CPT-4: XX) or fluoroscopy (CPT-4: XX). XX got about 65-70% relief at rest but if XX starts to increase XX activities XX pain level increases to 5-6/10 in XX XX. The shooting pain radiating down XX XX has improved. The XX pain increases with rising from a seated position, walking, and XX is difficult. XX does have a XX. Motor and sensory intact, SI.R negative XX, limit ROM ext-flex due to pain. XX is working full time and wants to avoid of having another fusion. Continue current medications and reporting any side effects. Body mechanics and core strengthening we3re discussed with the patient to accommodate their XX pathology. Continue home exercise program.

XX – URA Determination-XX: XX, is certified by The Texas Department of Insurance to perform workers' compensation utilization review. The use of the word you within this document shall mean the injured employee, employee representative, or the employee's providers. XX has been asked to review the treatment request listed below for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor made the following determination. Services Requested: Monitored anesthesia by an on call CRNA (XX) – Determination: Non-certified; XX XX nerve root block with fluoroscopy (XX) – Determination: Non-certified. Diagnosis/Description: XX-XX XX disorders w/radiculopathy, XX region; XX-Fusion of XX, XX region; XX-Other XX degeneration, XX region; XX-XX XX, XX region with XX; XX-XX w/o XX or radiculopathy, XX region. Clinical Summary: XX year old XX with injury date of XX. The patient had an XX-XX fusion in XX. MRI of XX showed a XX at XX-XX impacting the XX. XX has had PT. XX had a XX XX transforaminal with anesthesia on XX and noted 70% relief as of XX. XX pain score was 4/10 and XX had reduced XX flexor strength on that exam. XX has CAD, a XX placed, HTN, and high XX. XX BMI is XX and XX has no XX issues. Decision: Non-Certified. Clinical Rationale: The patient had good response to the prior XX XX TFE, but it has not been XX weeks yet to verify a full therapeutic result as per ODG requirements. Also, XX only has XX-sided findings on exam so this does not support a XX injection. The patient will need to be reassessed on or after XX to verify ODG requirements for a repeat injection have been met.

XX – URA Re-Determination-XX: XX, is certified by The Texas Department of Insurance to perform workers' compensation utilization review. The use of the word you within this document shall mean the injured employee, employee representative, or the employee's providers. XX has been asked to review the treatment request listed below for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor made the following determination. Services Requested: Monitored anesthesia by an on call CRNA (XX) – Determination: Non-certified; XX XX nerve root block with fluoroscopy (XX) – Determination: Non-certified. Diagnosis/Description: XX-XX disc disorders w/radiculopathy, XX region; XX-Fusion of XX, XX region; XX-Other XX disc degeneration, XX region; XX-XX XX, XX region with neurogenic claudication; XX-XX w/o XX or radiculopathy, XX region. Clinical Summary: The documentation submitted for review indicates that the claimant is a XX year old individual who reports sustaining an injury on XX. The claimant has complaints of XX XX pain. The claimant has a history of XX fusion XX-XX in XX. XX XX MRI dated XX shows a XX disc XX flattening the XX at XX-XX. There is marked XX. There is moderate XX. There is moderate to marked XX secondary to XX disc. There is mild to moderate XX. The claimant underwent XX XX XX nerve transforaminal ESI with total IV anesthetic (as the claimant is XX to XX and XX) on XX. On XX, the claimant notes XX XX XX pain and XX extremity pain in the anterior XX region. The claimant rates the XX pain as 3-7/10 and the extremity of pain as 3-4/10. The provider reports the anesthetic blockade of the XX transforaminal injection on 10/5/18 produced complete relief of the claimants usual pain, and the claimant has experienced a positive steroid

response with 70% relief of symptoms lasting to date. Exam shows normal pinprick sensation XX. There is 4/5 XX flexor strength (XX/XX XX-XX). XX XX and XX reflexes are 0+/5. Straight XX raising test is negative XX. The provider notes the claimant has XX and recommends transforaminal ESI at the XX XX. On XX, the provider notes the claimant still has about 60% relief, but continues to have XX XX pain radiating in the XX distribution. There is pain with flexion and positive XX straight XX raise for the XX. The provider states the claimant also requires sedation because of XX and takes XX XX times daily. Decision: Upheld. Clinical Rationale: ODG-TWC provides criteria for the use of ESI including radiculopathy due to XX, but not XX XX. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. If after the initial block/blocks are given and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. ODG-TWC states that there is no evidence-based literature to make a firm recommendation as to sedation during an ESI. Routine use is not recommended except for patients with XX. In this case, the current request does not meet guidelines. There is insufficient evidence of sustained functional improvement and decreased medication use after the previous ESI performed on XX. XX neurologic compromise related to the requested level is not outlined on examination. Given these noted factors, the medical necessity of a repeat procedure is not established. Recommendation is to deny XX XX nerve root block with fluoroscopy (XX) and monitored anesthesia by an on call CRNA (XX).

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

The request for repeat XX XX nerve root block is denied.

The patient is a XX year-old XX who continues to have XX XX pain and radicular symptoms following a XX XX fusion XX-XX. The XX XX XX XX MRI confirmed solid XX fusion at XX-XX and XX-XX. XX had XX degeneration at XX-XX associated with significant XX and moderate XX. Moderate to marked XX was noted on the XX side at XX-XX. Mild to moderate XX was noted on the XX side. XX underwent XX XX nerve root blocks in XX. On XX, the patient reported 60% pain relief with continued pain in both XX. The treating physician has recommended repeat XX XX nerve root blocks.

The Official Disability Guidelines (ODG) supports epidural steroid injections (ESI) for radiculopathy in which objective physical findings correlate a XX identified on an imaging study. The ODG does not support a series of epidural steroid injections. A second injection is not recommended without a significant response to the first injection.

This patient has had some pain relief with the first set of XX injections. The degree of improvement in radicular symptoms is not clear. There is no documentation of improved function or decreased need for pain medication following the XX injections. The XX XX MRI confirmed more severe nerve XX in the XX XX-XX XX, as compared to the XX; this factor calls into the question the need for a XX procedure.

A second set of XX XX injections is not medically necessary.

Per ODG:

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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**
- ☐ **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)**