True Resolutions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 2/11/2019 3:14:25 PM CST

True Resolutions Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #624
Mansfield, TX 76063
Phone: (512) 501-3856
Fax: (888) 415-9586
Email: manager@trueresolutionsiro.com

IRO REVIEWER REPORT

Date: 2/11/2019 3:14:25 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX, XX Transforaminal ESI with Fluoroscopy with Monitored Anesthesia

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-XX is a XX-year-old XX who, on XX, reported that XX had XX pains for about XX to XX months from XX XX XX XX on a XX. XX was diagnosed with sprain of XX of XX XX, initial encounter (XX.XX). Per an office visit dated XX by XX / XX, XX. XX-XX presented for XX XX pain and XX XX pain. The XX XX XX pain was rated at 7/10. The symptoms were somewhat worse since the prior evaluation. XX also complained of XX XX XX pain in the XX XX, XX XX, XX XX, XX diffusely and anterior XX region, and numbness in the XX XX, XX XX, XX medially, XX diffusely and anterior XX region. The associated symptoms were XX numbness and weakness in the XX. On examination, XX appeared XX XX and in XX XX. The XX examination revealed moderate protuberance. The pinprick sensation was decreased (XX) in the XX XX into the XX XX area and down to the XX XX region; XX down the outside of the XX / XX of the XX, into the XX / XX, and into the middle of the XX; and XX down to the XX and into the outer XX area. The reflexes were 2+/5 at XX XX, 1+/5 at XX XX, and 0+/5 at XX XX (XX). The gait was tandem with normal station. Straight XX raise testing while seated was positive on the XX for radiating XX pain and XX XX pain. The point of maximum tenderness was the XX XX XX XX. The XX range of motion was limited in flexion and extension by pain. The plan was to proceed with XX selective nerve root block / transforaminal epidural steroid injections at XX XX and XX. XX documented that XX. XX-XX had suffered for greater than XX weeks from radicular symptoms with an identifiable XX nerve etiology. Prior diagnostic transforaminal injection had provided significant relief for extended duration allowing clear improvement in function while residual symptoms remained. There were documented findings on examination supporting a radicular pathology. MRI findings were consistent with pathology, either XX, XX recess or XX XX, likely to cause radicular pathology. Past XX

therapy / nonsteroidal anti-inflammatory drugs / muscle relaxants had failed to control symptoms. There were no positive Waddell's signs or evidence of XX pathology that would preclude performance of the recommended transforaminal injection procedure. Fluoroscopic guidance was indicated to assure proper injection placement and to optimize outcome. XX. XX-XX had good relief with injection on XX for XX to XX weeks, was able to decrease medications at that time, and functional capacity of activities of daily living increased. Due to delicate nature of the procedure coupled with work in a sensitized / painful area around vital XX structures in a patient with XX, anesthesia services were indicated for patient comfort and safety. An MRI of the XX XX dated XX revealed XX-XX XX XX XX XX of XX mm, XX-XX XX XX XX of XX mm, and XX-XX XX XX and XX XX XX of XX mm. The treatment to date included medications (XX with good relief), XX therapy and activity modification (not helpful) and transforaminal steroid injections on XX (65% relief for XX weeks).Per a utilization review decision letter dated XX, the request for XX XX-XX transforaminal epidural steroid injection (ESI) with fluoroscopy with monitored anesthesia was denied by XX. Rationale: “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, repeat ESI should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. In this case, it was noted that the patient had transforaminal steroid injection (XX) and had 60 percent relief of symptoms that lasted XX weeks improvement in function while residual symptoms remain. However, the submitted medical report after the initial ESI had limited evidence of significant objective changes of improvement and its efficacy to support a duration of pain relief and improvement in function for XX to XX weeks from the prior (ESI) before considering a repeat procedure. Per a utilization review decision letter dated XX, the prior denial was upheld by XX. Rationale: “Per evidence based guidelines, repeat ESI should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. On XX, the patient had a XX transforaminal injection at the XX XX and XX under fluoroscopy guidance. However, it gave 60 percent relief of symptoms that only lasted three weeks improvement in function while residual symptoms remain. The pain relief of at least 50-70 percent pain relief for at least XX to XX weeks was not established. The objective efficacy in response to the recent ESI provided was not fully established. There was also limited evidence of significant clinical changes after the injection as well as an education in medication use and significant change in pain levels. Exceptional factors could not be identified. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced, this request is non-certified. The pain relief of at least 50-70 percent pain relief for at least XX-XX weeks was not established. The objective efficacy in response to the recent ESI provided was not fully established.”

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-XX transforaminal epidural steroid injection (ESI) with fluoroscopy with monitored anesthesia, dated XX, XX - Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); XX or XX, single level, XX - Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); XX or XX, each additional level (List separately in addition to code for primary procedure), XX - Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review decision letter dated XX, the request for XX XX-XX transforaminal epidural steroid injection (ESI) with fluoroscopy with monitored anesthesia was denied by XX. Rationale: “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, repeat ESI should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. In this case, it was noted that the patient had transforaminal steroid injection (XX) and had 60 percent relief of symptoms that lasted XX weeks improvement in function while

residual symptoms remain. However, the submitted medical report after the initial ESI had limited evidence of significant objective changes of improvement and its efficacy to support a duration of pain relief and improvement in function for XX to XX weeks from the prior (ESI) before considering a repeat procedure. Per a utilization review decision letter dated XX, the prior denial was upheld by XX. Rationale: "Per evidence-based guidelines, repeat ESI should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. On XX, the patient had a XX transforaminal injection at the XX XX and XX under fluoroscopy guidance. However, it gave 60 percent relief of symptoms that only lasted XX weeks improvement in function while residual symptoms remain. The pain relief of at least 50-70 percent pain relief for at least XX to XX weeks was not established. The objective efficacy in response to the recent ESI provided was not fully established. There was also limited evidence of significant clinical changes after the injection as well as an education in medication use and significant change in pain levels. Exceptional factors could not be identified. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced, this request is non-certified. The pain relief of at least 50-70 percent pain relief for at least XX-XX weeks was not established. The objective efficacy in response to the recent ESI provided was not fully established." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient underwent XX XX-XX transforaminal epidural steroid injection on XX. Follow up note dated XX indicates that pain level is 7/10 VAS. Current treatment is noted to include activity modification and transforaminal steroid injections. It is reported that "the current treatment is providing little relief of current symptoms." The patient reported 65% pain relief for only XX weeks. The Official Disability Guidelines require documentation of at least 50% pain relief for at least XX-XX weeks prior to repeat epidural steroid injection. Therefore, given the documentation available, the requested service(s) is considered not medically necessary in accordance with current evidence-based guidelines and the decision is upheld.

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

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

See the XX Chapter, where ESIs are not recommended based on recent evidence, given the serious risks of this procedure in the XX region and the lack of quality evidence for sustained benefit. Criteria for the use of Epidural steroid injections: