Core 400 LLC

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

XX XX steroid injection at XX-XX.

XX Injection(s), including indwelling XX XX, continuous infusion or intermittent XX, of diagnostic or therapeutic substance(s) (eg, anesthetic, XX, XX, steroid, other solution), not including XX substances, XX XX or XX, XX or XX (XX); without imaging guidance

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

Board Certified Internal Medicine

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. XX was XX a XX XX-XX XX XX an XX, when it XX to XX XX XX XX. As XX resisted, XX the XX, XX XX a XX in XX XX XX XX. XX was diagnosed with XX XX and sprain of XX of the XX XX.

XX evaluated XX. XX on XX for XX pain. XX. XX stated that XX continued to have XX pain. XX had shown no improvement from the prior visit. The pain was rated at 8/10. XX complained of XX XX XX pain since the XX in early XX. XX stated that XX XX XX symptoms including pain, range of motion, and radiating pain had remained the same. The XX pain radiated to the XX XX, and it also radiated to both XX (XX was not consistent with XX answer). XX had XX and XX with intermittent XX in the XX of the XX XX and very occasionally also on the XX. XX had XX extremity weakness, XX more than the XX. The examination showed decreased XX range of motion in all planes with XX XX along the XX XX and tenderness, decreased muscle strength, XX more than the XX, and significant XX pain without XX on XX XX XX XX. XX. XX was on restricted duty.

An MRI of the XX XX dated XX showed XX XX XX with XX XX at XX-XX without XX of the descending XX XX XX or significant narrowing.

The treatment to date consisted of medications (XX and XX) and XX therapy.

Per an adverse determination letter dated XX by XX, the appeal request for XX XX steroid injection at XX-XX was not certified. Rationale: “During the peer to peer discussion, XX said that this was requested because the patient has XX pain with weakness in both XX, the XX is worse than the XX. XX stated that XX is having a lot of persistent pain which is about 8/10. XX is taking XX and XX XX and XX believes that XX had issues with XX upset with XX. Guidelines state that therapeutic XX steroid injections (XX) may be 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 rehab efforts. In this case, although the MRI of the XX XX on XX shows XX XX XX with an XX XX at XX-XX, it also noted that it is without displacement of the descending XX XX XX or significant narrowing.

Furthermore, the medical records do not establish clinical findings on physical examination consistent with an objective XX XX XX in a XX or XX pattern that would cause concern for XX compromise or XX stemming from the XX XX. The neurological examination in XX XX report only documents generalized muscle strength that is decreased in the XX XX extremities, XX greater than XX. This could be due to pain. A clear diagnosis of XX would be supported with sensory deficits in a XX pattern or a XX distribution of weakness. Without specific clinical findings that correlate with a specific XX XX level, the requested XX injection is not supported. Given these reasons, the medical necessity for this request has not been established. Optimizing the use and dose of XX XX XX including XX and XX XX-XX such as XX and XX-XX such as XX and using non-XX XX are recommended alternatives to treat the chronic pain. Should additional information become available that may have a bearing on this decision, such as failure of adequate trials and XX of XX XX and XX or XX deficits, this request can be resubmitted for further consideration. Therefore, my recommendation is to non-certify the request for an XX steroid injection at XX-XX."

Per an adverse determination letter dated XX by XX, the appeal request for XX XX steroid injection at XX-XX was denied. Rationale: "The request to be based on the fact that the claimant has subjective reports of pain that occur more with mobilization. I had specifically discussed the results of the MRI that did not reveal any XX XX impingement or objective neurologic findings during any other visits. XX response was that the MRI was a largely ecstatic test that would not reveal impingement that could occur during periods when the claimant would be mobilizing XX XX. However, the request is for an XX steroid injection and would typically only be given when there are objective findings of XX XX impingement. Therefore, my determination is that the initial denial should be upheld and alternative treatments should be pursued."

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 steroid injection at XX-XX XX Injection(s), including indwelling XX XX, continuous infusion or intermittent XX, of diagnostic or therapeutic substance(s) (eg, anesthetic, XX, XX, steroid, other solution), not including XX substances, XX XX or XX, XX or XX (XX); without imaging 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 XX on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's XX MRI fails to document significant neurocompressive pathology at the XX-XX level. The MRI notes that there is a XX XX XX XX XX with XX which does not displace the descending XX XX XX. There is no significant narrowing. The most recent physical examination submitted for review is from XX. 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 Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards

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- ☐ 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.