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An Independent Review Organization
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12/27/18

Description of the service or services in dispute:

XX

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

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)

XXXX. XXXX was diagnosed with sprain of ligaments of the XX XX, initial encounter (XX).

XXXX was evaluated by XXXX on XXXX for the complaints of XX pain and XX XX pain. XXXX was able to stand, sit, and walk for more than XX minutes. The pain was described as constant, aching, numbness and shooting type with a tingling sensation. The pain was rated as XX/10. XXXX was working light duty. The examination showed decreased XX range of motion on flexion, extension and bilateral rotation. XX tenderness was noted in the XX area on the XXXX side. XX pain on XX rotation / extension / flexion and palpation and axial loading in the XX XX. XXXX was re-evaluated on XXXX, where XXXX complaints and physical examination remained unchanged from the prior visit.

On XXXX, XXXX had a physical therapy initial evaluation by XXXX. XXXX complained of pain on the XXXX XX, XX and arm. XXXX was XXXX which might be affecting XXXX physical performance. XXXX was on light duty with restrictions. On examination, the gait was XX and XXXX was protecting / guarding XXXX arm due to pain. The XXXX XX manual muscle testing strength was noted as XX/5 with all XX ranges of motion. There was tenderness to palpation from XX, XXXX XX / XX, arm to elbow and all over on the XXXX side. There were activity limitations with lifting, carrying, handling, pulling and pushing. Overall assessment showed decreased range of motion, strength, function and pain. XXXX had ongoing physical

therapy sessions on XXXX. On XXXX, XXXX had the forth physical therapy evaluation, where XXXX reported that the pain never stopped. The pain was rated as XX/10. The pain medications were working a little. XXXX was highly sensitized and pain focused but with application of XXXX was able to perform the exercises without XXXX pain escalating beyond XXXX ongoing pain.

An MRI of the XX XX dated XXXX showed a normal vertebral body height, normal alignment with XX disc narrowing at XX and XX. At XX, there was XX-mm central disc protrusion not contacting neural structures and mild XX arthropathy. Mild central XX stenosis of XX mm was noted. At XX, there was a XX-mm broad-based disc XX XX, moderate XX uncovertebral joint arthropathy and moderate XX XX arthropathy. Mild central canal XX of XX mm was noted. There was moderately-severe XX XX narrowing with potential impingement on the exiting XX nerve roots. At XX, there was a XX-mm broad-based disc XX protrusion, mild XX facet arthropathy and XX uncovertebral joint XX noted. Central canal was borderline at XX mm. There was mild XX XX narrowing. X-rays XX XX and the XXXX shoulder dated XXXX were negative for fracture and dislocation.

Treatment to date included medications (XXXX with no help), XX sessions of physical therapy (no help), and injections (XXXX).

Per a utilization review determination letter dated XXXX, the request for XX XX blocks at XX-XX and XX-XX levels medial branch of the XX ramus on the XXXX was not certified. Rationale: "Per evidence-based guidelines, XX joint diagnostic blocks are recommended prior to XX neurotomy. It is limited to patients with XX pain that is non-radicular and at no more than two levels XX provided that there is a documentation of failure of conservative treatment for at least XX to XX weeks. The patient had tried multiple sessions of physical therapy with minimal or no help. Although there were objective deficits, there was limited documentation of quantifiable objective findings in the most recent report to determine the degree or extent of deficit. There should also be documentation regarding the muscle strength, sensation, and deep tendon reflexes. Furthermore, the extent of XXXX XX to XX was not clear and could possibly negate the results of the procedure if using an IV sedation." It was determined that the notes stated XXXX had attended recent XX sessions of PT; however, there were no notes of XX to XX weeks of completed physical therapy. Moreover, the description of the pain as shooting suggested XX, and discussion with the provider was required to clarify if that was the situation.

A letter dated XXXX indicated that the reconsideration request was denied / non-certified. Rationale: "Per evidence-based guidelines, XX joint diagnostic blocks is recommended prior to facet XX. It is limited to patients with XX pain that is non-XX and at no more than XX levels XX provided that there is a documentation of failure of conservative treatment for at least XX to XX weeks. The patient had tried multiple sessions of physical therapy with minimal or no help. However, it was documented that XXXX had numbness, shooting, and a tingling sensation in the XXXX XX XX. Facet-mediated pain should be XX either with no XX or rarely past the XX. There should also be documentation regarding the muscle strength, sensation, and deep tendon reflexes."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient presents with a classic picture of XX mediated pain in the XX region. Pain is worsened with axial rotation and with XX loading. Conservative treatment has failed. PT was attempted but XX pain after a few sessions. The clinical examination supports a XX syndrome – no weakness or sensory loss. The MRI corroborates the clinical picture. Two prior reviews were not supportive of the request in that conservative therapy was no adequate and XX symptoms were present. However, the pain in the patient's XX XX was not XX in nature. The request for sedation is not unreasonable, since it only utilizes XXXX. So, this should not obscure the response. Given the documentation available, the requested service(s) is considered medically necessary.

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

☐ Mercy Center Consensus Conference Guidelines

☐ Milliman Care Guidelines

☑ ODG-Official Disability Guidelines and Treatment Guidelines

ODG® 2018 Official Disability Guidelines® (23rd annual edition) & ODG® Treatment in Workers' Comp (16th annual edition)

ODG-TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines - XX and XX XX
(updated 12/12/2018)

XX

☐ 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 right 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.