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Reviewer's Report

DATE OF REVIEW: 01/10/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Authorization and coverage for outpatient XX transforaminal epidural steroid injection at XX-XX, XX-XX at XX as requested by XX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Physical Medicine & Rehabilitation, Pain Management.

REVIEW OUTCOME

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

☐ Upheld (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

I have determined that the requested is medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured worker is a XX-year-old XX with a remote work injury occurring at the age of XX with date of injury on XX.

XX underwent a XX XX in XX.

Recent diagnostic testing includes an MRI scan of the XX XX on XX showing findings of mild XX XX at XX and XX with minimal XX at XX. There was mild to moderate XX XX encroachment at XX with mild XX XX at XX and minimal XX at XX. There was XX XX.

XX was seen for an evaluation on XX. XX had sharp XX pain radiating down the XX leg with numbness in XX XX foot. XX had pain ranging from XX/10 with a current pain score of XX/10.

XX current medications included XX, XX, XX, XX-XX, and XX.

Physical examination findings included exacerbation of pain with straight leg raising at XX degrees. There was XX XX tenderness with findings of XX greater than XX radiculopathy noted. XX had XX greater than XX radicular symptoms with the distribution of pain traveling along the XX and XX XX distribution. XX had abnormal gait, reflexes, sensation, and strength including decreased strength with XX and XX especially down the XX XX extremity.

XX treatments were reviewed and had included XX sessions of physical therapy. Recommendations included XX XX transforaminal epidural injections with a prior injection providing XX% overall reduction in pain which had lasted for more than XX months.

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

In the therapeutic phase, ODG guidelines recommend that a repeat epidural steroid injection should be based on continued objective documented pain and functional improvement, including at least 50% pain relief for XX weeks.

In this case, the claimant had undergone a prior transforaminal epidural injection providing XX% relief lasting for more than XX months. Physical examination findings support the presence of XX XX XX and conservative treatments have been provided, including recent physical therapy and medications. Current medications include XX, which is relatively contraindicated as XX has a history of XX being treated with medications.

Despite XX treatments, XX has ongoing moderate pain with pain ranging as high as XX/10.

The epidural steroid injection performed was appropriate and medically necessary.

Therefore**,** I have determined the requested is medically necessary for treatment of the patient's medical condition.

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 BACK 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)**