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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 1/15/2019 10:28:53 AM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX transforaminal XX, XX-XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Pain Medicine, Physical Medicine & Rehab

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 is a XX-year-old XX who was injured on XX. XX was XX, XX. The ongoing diagnosis included XX XX pain (XX). XX. XX was seen by XX on XX for XX pain. XX stated that XX injured XX XX on XX. XX had an injury to the XX before, but this had been the most painful issue, which XX had ever experienced. The pain was located at the XX XX at XX. It was described as a constant spasm in the XX and XX XX with pins. and needles as well as a burning sensation. The severity of the pain varied between XX/10 depending on XX activity. XX stated that XX could not get better XX unless XX took a XX XX. The modifying factors included rest, medication, therapy, stretches, ice, and heat packs. On examination, there was tenderness to palpation over the XX XX. XX presented with XX greater than

XX XX XX XX. The gait was XX. XX was noted. There was some difficulty with XX. There was tenderness to palpation over the XX and XX regions. Increase in activity made it difficult for XX to XX as the XX pain extended down along the XX and XX. Straight leg raise was at XX degrees, which exacerbated the overall pain especially causing XX down to the XX XX extremity. XX examination revealed XX reflexes, XX sensation, and XX strength. The deep tendon reflexes remained XX. There was decreased strength and decreased range of motion. XX recommended a XX-sided XX steroid injection at XX and XX.X-rays of the XX XX dated XX showed XX of XX on XX from moderate-to-severe XX with moderate XX changes. There was mild XX and moderate-to-severe XX changes. A XX MRI accomplished on XX revealed findings consistent with the presence of degenerative changes in the XX XX with a grade I XX XX of XX on XX. The treatment to date included medications (XX, XX, XX, XX, and XX), rest, ice, heat packs and XX sessions of physical therapy (with 5-10% improvement). Per a utilization review decision letter dated XX by XX, the request for "XX" XX epidural steroid injection at XX and XX was denied. Rationale: "Based upon the medical documentation presently available for review, Official Disability Guidelines (ODG) would not support medical necessity for this specific request as submitted. The records available for review do not provide data to indicate the presence of a compressive lesion upon a neural element in the XX XX on objective diagnostic testing that is available for review. Consequently, presently, medical necessity for this specific request as submitted is not established per criteria set forth by the above-noted reference. Attempts at conducting a PEER to PEER review were not successful." Per a utilization review decision letter dated XX, the request for "XX" transforaminal epidural steroid injection at XX and XX was not medically necessary. Rationale: "According to Official Disability Guidelines (ODG), the purpose of an epidural steroid injection (ESI) is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery. The guidelines require documentation indicative of XX documented by physical examination and corroborated by imaging studies and or electrodiagnostic testing that is initially unresponsive to conservative treatment such as exercises, physical methods, NSAIDs and muscle relaxants. In this case, the patient has XX XX pain with radiation to the XX XX XX. There was a previous adverse determination dated XX, whereby the previous reviewer noted the records available for review did not provide data to indicate the presence of a compressive lesion upon a neural element in the XX XX on objective diagnostic testing that was available for review. Thus, the request was denied. Upon reconsideration, submitted as part of this review is an MRI report from XX showing grade 1 XX of XX on XX and a mild XX at XX-XX without XX XX or XX." The findings on MRI are not consistent with the qualifying criteria set forth by the applicable guidelines as XX does not appear to be the likely etiology of the patient's pain. A successful peer-to-peer call with XX was made at XX. We discussed the patient medical history along with the guidelines and request in detail. XX states that on the physical exam, the patient has some XX pain but most of the patient's pain is XX in the XX distributions of XX and XX. XX advised that the patient had little improvement after XX sessions of physical therapy, "maybe 5 - 10% improvement." XX says that their intent is to re-engage the patient in physical therapy after the requested epidural steroid injection (ESI). XX asserts that the patient's ability to fully participate in physical therapy was limited due to pain. The patient is not on any narcotics. XX states that the patient has tried XX in the past, but it was discontinued due to adverse effects. XX says that the patient was recently prescribed XX but it is unknown if the patient has started taking the medication and if so if the patient has derived benefit from it. As such, it remains unknown if the patient's pain is responsive to standard conservative treatments, specifically XX in this case. Compliance with the aforementioned guidelines is not apparent, therefore, the request is denied."

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

There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. There is no significant XX pathology documented on the submitted XX MRI. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. The

findings on MRI are not consistent with the qualifying criteria set forth by the applicable guidelines as XX does not appear to be the likely etiology of the patient's pain.
Given the documentation available, the requested service(s) is considered not medically necessary and the request is upheld.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Criteria for the use of Epidural steroid injections: