IRO Express Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 1/22/2019 10:57:35 AM CST

IRO Express Inc.

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IRO REVIEWER REPORT

Date: 1/22/2019 10:57:35 AM CST

IRO CASE #: XX

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

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 is a XX-year-old XX who was injured on XX. XX was involved in a XX and had an injury to the XX, XX XX, XX XX, XX XX, and XX XX. XX. XX was seen by XX on XX for a follow-up of XX ongoing complaints. XX reported XX pain, which was intermittent and located over the XX XX XX to the XX and XX upper XX and XX. There was mild limitation of XX, XX, and XX XX rotation. The pain was XX/10. There was tenderness over the XX XX area. The XX XX pain was rated at XX/10, which was intermittent over the XX XX XX to the XX XX, XX / XX XX, XX, and all XX. XX had XX inches less full XX touched from the XX XX. There was moderate limitation of the XX and XX XX XX and XX of the XX XX. There was tenderness over the XX XX area. The XX XX pain was rated at XX/10, which was intermittent over the XX and XX XX. The XX XX pain was rated at XX/10, which was intermittent over the XX XX. The XX XX pain was

rated at XX/10, which was intermittent with tenderness over the XX XX with full range of motion. The plan was to proceed with XX injection on the XX at XX-XX and XX-XX. An MRI of the XX XX dated XX showed prominent XX and XX XX XX XX XX with XX XX. There was significant XX XX XX XX, probable XX XX XX XX compromise. There was also XX and XX XX XX XX with displacement and possible compromise of the XX XX XX, more prominent on the XX than the XX. The treatment to date included medications (XX, XX, and XX), which were helpful, activity modifications, and physical therapy. Per a utilization review decision letter and peer review dated XX, the request for XX XX-XX and XX-XX was denied by XX. Rationale: "As per the Official Disability Guidelines (ODG), 'XX.' The injured worker has persistent XX XX pain over the XX XX XX to the XX XX, XX / XX XX, XX, and all XX with numbness, and tingling. Examination revealed moderate limitation of XX and XX XX XX and XX of the XX XX. XX is neurologically intact. There is tenderness over the XX XX area and over the XX XX at XX-XX and XX-XX. Imaging related XX XX XX (XX) at XX and XX XX at XX-XX and XX-XX. Non-operative treatment in the form of physical therapy, medications, and activity modifications has been tried and failed. However, as per recent guidelines, XX injections are not recommended. Additionally, in this clinical context of at least XX, these injections have not been fully proven in the medical literature to be an effective treatment. Therefore, this request is not medically reasonable and necessary at this time." Per a utilization review decision letter dated XX and peer review dated XX, the request for XX XX-XX and XX-XX was denied. Rationale: "In this case, the procedure is not indicated given that the documentation does not note any XX pathology or symptoms. The MRI noted XX XX with XX XX XX involvement. Thus, the request is not congruent with the documentation. Therefore, the request for XX XX-XX, XX-XX XX injection is not medically necessary."

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 and XX-XX XX injections is not recommended as medically necessary. Per a utilization review decision letter and peer review dated XX, the request for XX XX-XX and XX-XX was denied by XX. Rationale: "As per the Official Disability Guidelines (ODG), 'XX.' The injured worker has persistent XX XX pain over the XX XX XX to the XX XX, XX / XX XX, XX, and all XX with numbness, and tingling. Examination revealed moderate limitation of XX and XX XX XX and XX of the XX XX. XX is neurologically intact. There is tenderness over the XX XX area and over the XX XX at XX-XX and XX-XX. Imaging related XX XX XX (XX) at XX and XX XX at XX-XX and XX-XX. Non-operative treatment in the form of physical therapy, medications, and activity modifications has been tried and failed. However, as per recent guidelines, XX injections are not recommended. Additionally, in this clinical context of at least XX, these injections have not been fully proven in the medical literature to be an effective treatment. Therefore, this request is not medically reasonable and necessary at this time." Per a utilization review decision letter dated XX and peer review dated XX, the request for XX XX-XX and XX-XX was denied. Rationale: "In this case, the procedure is not indicated given that the documentation does not note any XX XX or symptoms. The MRI noted XX XX with XX XX XX involvement. Thus, the request is not congruent with the documentation. Therefore, the request for XX XX-XX, XX-XX XX injection is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. Per peer review dated XX, compensable diagnoses include a XX strain, XX strain, XX XX strain and XX XX strain. The compensable injuries would have resolved within XX-XX weeks regardless of treatment rendered. The most recent physical examination fails to establish the presence of XX mediated pain. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

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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

See XX XX pain, signs & symptoms; XX XX radiofrequency neurotomy; XX XX XX XX XX (therapeutic injections); and XX injections (therapeutic blocks). See also XX Chapter and Pain Chapter. Criteria for the use of diagnostic blocks for XX "XX" pain: