Independent Resolutions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 1/9/2019 Amended 1/9/2019

Independent Resolutions Inc.

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IRO REVIEWER REPORT

Date: 1/9/2019 Amended 1/9/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: ***XX XX, XX XX XX with fluoroscopy and Monitored Anesthesia***

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 sustained an XX on XX. The biomechanics of the injury was not available in the medical records. XX is status post XX XX XX of XX-XX in XX. XX was diagnosed with XX XX XX at XX-XX.XX. XX was seen by XX on XX for XX XX pain. XX complained of XX XX XX pain and XX XX pain, rated at XX/10. The symptoms were unchanged from the prior visit. XX also reported XX XX XX pain in the XX XX. On examination, XX was XX XX with mild distress. The pinprick sensation was decreased (XX) in the XX XX into the XX XX area and down to the XX XX region. The strength was XX+/5 over the XX XX (XX-XX), XX XX XX (XX), XX XX XX XX XX (XX), and XX-/5 XX XX (XX). The reflexes were XX+/5 over the XX XX and XX XX. XX XX raise testing while seated was positive XX for radiating XX pain. Examination of the XX XX showed XX XX XX XX XX and XX XX XX XX. There was maximum tenderness over the XX lower XX XX and XX XX XX. The usual pain was aggravated with XX greater than extension. The diagnoses were XX XX – XX extremities, postoperative XX XX, XX XX ow XX – central XX-XX and central XX-XX, XX XX XX and XX XX, XX secondary to XX XX XX at XX XX, XX XX, and XX XX levels, and XX XX XX. XX noted that XX. XX had suffered

for greater than XX weeks from XX symptoms with an identifiable XX XX XX. Prior diagnostic transforaminal injections had provided significant relief for extended duration, allowing clear improvement in function while residual symptoms remained. There were documented findings on examination supporting a radicular pathology. MRI findings were consistent with pathology, either XX, XX recess or XX XX, likely to cause XX pathology. Past physical therapy / nonsteroidal anti-inflammatory drugs / muscle relaxants had failed to control symptoms. There were no positive XX signs or evidence of psychosocial pathology that would preclude performance of the recommended transforaminal injection procedure. XX guidance was indicated to assure proper injection placement and to optimize diagnostic outcome. A XX XX steroid injection at XX XX and XX was requested. An MRI of the XX XX dated XX showed postoperative XX XX with XX greatest at XX-XX, where there was moderate to severe XX XX XX. The treatment to date included medications (XX, XX, XX, and XX,), which provided moderate relief, XX XX and XX XX XX injections with transforaminal XX steroid injections under XX on XX (XX% relief), physical therapy, and surgical interventions including posterior XX XX XX in XX.Utilization review decision letters dated XX and XX were included in the medical records. Per a utilization review decision letter dated XX, the request for transforaminal XX steroid injection with XX and monitored anesthesia at XX and XX was denied by XX. Rationale: "The patient has not had XX to XX weeks of pain relief with noted reduction of medication and improved functionality as a result of the XX XX. The Official Disability Guidelines require 50-70% pain relief for at least XX to XX weeks and repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. As per the guidelines, when considering a second XX XX injection, there needs to be evidence of at least 50-70% pain relief for at least XX to XX weeks. This patient was reevaluated only XX month following the initial injection. It would be too soon to consider a repeat injection at this juncture. Furthermore, guidelines state that repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. The medical records do not establish a reduction of medication or improved functionality specifically resulting from the prior epidural steroid injection. Therefore, my recommendation is to non-certify the request for transforaminal epidural steroid injection with XX and Monitored Anesthesia at XX XX and XX."Per a utilization review decision letter dated XX, the requested service of transforaminal XX XX injection with XX and monitored anesthesia at XX and XX was denied by XX. Rationale: "The patient has not had reduction of medication and improved functionality as a result of the initial epidural. The clinical basis for denying these services or treatment: The Official Disability Guidelines require that repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. When considering a repeat epidural steroid injection, Official Disability Guidelines (ODG) guidelines require that a patient have decreased need for pain medications and functional response. The medical records do not establish a reduction of medication or improved functionality specifically resulting from the prior XX XX injection. It is acknowledged that the patient notes reduction of pain. However, there needs to be reduction of medication as well as functional response to consider a repeat injection. Therefore, my recommendation is to non-certify the appeal for XX XX steroid injection with XX and Monitored anesthesia at XX XX and XX."

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 is not recommended as medically necessary. Per a utilization review decision letter dated XX, the request for XX XX steroid injection with XX and monitored anesthesia at XX and XX was denied by XX. Rationale: "The patient has not had XX to XX weeks of pain relief with noted reduction of medication and improved functionality as a result of the initial epidural. The Official Disability Guidelines require 50-70% pain relief for at least XX to XX weeks and repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. As per the guidelines, when considering a second epidural steroid injection, there needs to be evidence of at least 50-70% pain relief for at least XX to XX weeks. This patient was reevaluated only XX month following the initial injection. It would be too soon to consider a repeat

injection at this juncture. Furthermore, guidelines state that repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. The medical records do not establish a reduction of medication or improved functionality specifically resulting from the prior epidural steroid injection. Therefore, my recommendation is to non-certify the request for XX XX steroid injection with XX and Monitored Anesthesia at XX XX and XX." Per a utilization review decision letter dated XX, the requested service of XX XX steroid injection with XX and monitored anesthesia at XX and XX was denied by XX. Rationale: "The patient has not had reduction of medication and improved functionality as a result of the initial epidural. The clinical basis for denying these services or treatment: The Official Disability Guidelines require that repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. When considering a repeat epidural steroid injection, Official Disability Guidelines (ODG) guidelines require that a patient have decreased need for pain medications and functional response. The medical records do not establish a reduction of medication or improved functionality specifically resulting from the prior epidural steroid injection. It is acknowledged that the patient notes reduction of pain. However, there needs to be reduction of medication as well as functional response to consider a repeat injection. Therefore, my recommendation is to non-certify the appeal for XX XX steroid injection with XX and Monitored anesthesia at XX XX and XX." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted records indicate that the patient underwent prior XX XX XX injection at the requested level in XX. The submitted clinical records fail to document at least 50% pain relief for at least XX weeks with functional improvement as well as medication reduction following prior epidural steroid injection as required by the Official Disability Guidelines. 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.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Epidural steroid injections (ESIs), therapeutic