# Core 400 LLC

**An Independent Review Organization**
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## *Review Outcome*

***Description of the service or services in dispute:***

XX epidural steroid injection XX-XX on the XX, diagnostic

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|---|---|
| XX | Injection(s) of diagnostic or therapeutic substance(s) not including XX substances, including needle or catheter placement, XX epidural or XX, XX or XX (XX); with imaging guidance (i.e., fluoroscopy or CT) |
| XX | Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position |
| XX | Injection XX XX |
| XX | Injection XX XX per XX mg |

***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)***

XX. XX XX is a XX-year-old XX who was injured on XX. XX was XX and felt a severe pain in the XX back. XX also had numbness down the XX XX extremity. XX was diagnosed with XX XX XX of the XX region (XX.XX), XX side XX with XX (XX.XX), and strain of muscle, XX, and tendon of the XX back (XX.XX).

On XX and XX, XX evaluated XX. XX for recheck. On XX, XX. XX was a little XX about getting a XX epidural steroid injection for XX XX XX at XX-XX. In the meantime, XX had worsening of pain. XX was having severe pain, which radiated into the XX XX extremity, not helped by physical therapy or medication. On examination, toe and heel walking was poor on the XX. Straight leg raise was XX on the XX. There was decreased XX sensation in the XX XX-XX XX distribution. The assessment was XX sprain / strain. XX recommended that XX. XX proceed with a diagnostic XX-XX XX epidural steroid injection, as XX had XX-XX XX-mm disc herniation, XX XX. XX was quite XX of XX, so XX would need sedation. On XX, A diagnostic XX epidural steroid injection was denied, in spite of XX meeting Official Disability Guidelines (ODG). On examination, XX toe and heel walking were poor on the XX. Straight leg raise on the XX was positive. XX had decreased XX sensation at the XX XX-XX. The assessment was XX sprain / strain. The plan was to appeal denial of XX-XX XX epidural steroid injection on the XX.

On XX and XX, XX evaluated XX. XX for a follow-up on XX strain injury. On XX, XX. XX reported XX XX pain radiating to the XX XX, XX thigh and XX calf. The symptoms occurred frequently. The pain was severe. The associated symptoms included XX stiffness, decreased flexion, XX extremity numbness, and XX extremity tingling. Exacerbating factors included twisting, lifting, and bending. Relieving factors included nonsteroidal anti-inflammatory drugs and muscle relaxers. On examination, the XX XX had muscular and XX tenderness at XX, XX, and XX. Palpation revealed XX muscle spasms. XX. XX had limited range of motion. Flexion was XX

degrees and painful. XX XX XX was painful. XX had significant difficulties with the physical requirements of XX job. On XX, the pain level on the XX XX was XX/10. XX had pain at the XX thigh pain. XX had helped the pain.

X-rays of the XX XX dated XX, revealed XX in the XX XX XX, which was very suspicious for XX. An MRI of the XX XX dated XX, revealed mild XX of the XX and a XX XX broad-based XX XX indenting the XX XX XX at the XX-XX level. At the XX-XX level, there was XX of the XX with a XX XX broad-based XX XX XX indenting the XX XX XX. XX XX lateralized XX slightly more to the XX. Additionally, XX XX XX was identified at that level. At the XX-XX level, there was XX mild XX XX, XX more than the XX. XX was noted.

The treatment to date consisted of medications (XX, XX) and physical therapy.

Per an adverse determination letter dated XX, XX had non-authorized medical necessity for XX epidural steroid injection at XX-XX on the XX side. Rationale: "Based on the medical records submitted for review on the above referenced claimant, XX epidural steroid injection XX/XX on the XX side is not recommended. Exam findings are limited to XX sided XX, straight leg raise negative, decreased XX distribution in the XX XX-XX distribution, numbness down front of XX thigh. XX MRI XX XX-XX XX XX with XX XX XX. XX-XX no XX XX or protrusion. The XX MRI findings do not correlate to the exam findings."

Per an adverse determination letter dated XX, XX had non-authorized reconsideration for XX epidural steroid injection at XX/XX on the XX. Rationale: "Per ODG, therapeutic epidural steroid injections (ESI) are recommended for the treatment of XX XX pain with radicular symptoms. ESI are recommended as adjunct therapy intended to enable or better enable patient participation in active rehab efforts proven to provide long-term benefit. In this case, the patient has XX XX pain with physical exam findings consistent with radicular symptoms involving XX and XX, including decreased XX sensation in the XX leg, positive straight leg raise on the XX, and poor toe and heel walking. An MRI performed on XX, shows "XX broad-based XX XX XX indenting the XX XX XX" at XX-XX. The patient is reported to take XX and XX. The patient has participated in physical therapy; however, there is no mention of trial and failure or contraindication to the use of medications targeting neuropathic pain. Compliance with the aforementioned guidelines is not apparent. Medical necessity is not established with the information in the available medical records, thus, the request is nonauthorized."

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

This patient presents with XX pain down the XX leg, with loss of sensation down the XX thigh. The procedure requested is a diagnostic ESI at XX on the XX with sedation. The patient has expressed XX about the XX which is documented and therefore sedation is indicated under the ODG. The question is whether the request for the ESI meets the ODG. In addition, was the prior analysis by two prior independent reviewers which essentially denied the request for the ESI, accurate and reasonable? The first review dated XX, stated that there was a lack of correlation between the clinical presentation, i.e. XX leg pain and the MRI findings. An MRI of the XX XX dated XX, revealed mild XX of the XX and a XX XX broad based XX XX indenting the XX XX XX at the XX-XX level. At the XX-XX level, there was XX of the XX with a XX XX broad-based XX XX XX indenting the XX XX XX. XX XX lateralized XX slightly more to the XX. Additionally, XX XX XX was identified at that level. At the XX-XX level, there was XX mild facet XX, XX more than the XX. These findings do not suggest clear evidence of XX-sided XX XX XX, since the report states that the XX XX is XX at XX. In addition, facet XX is noted on the XX at XX. The second review dated XX stated that there was no mention of trial or failure – does this refer to the PT or medications targeting neuropathic pain? We know that PT was ineffective. Medications such as XX may have been attempted, but this is not documented. So, there are several issues that are somewhat unclear here. However, the patent is severely symptomatic and therefore, XX medical interests should be supported, since overwhelming evidence of non-compliance with the ODG is lacking. 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



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Case Number: XX Date of Notice: 01/17/19

- ☐ 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)

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- ☐ 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 XX 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.


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