# True Decisions Inc.

## *Notice of Independent Review Decision*

Case Number: XX Date of Notice: 3/22/2019 12:22:07 PM CST


# True Decisions Inc.

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**IRO REVIEWER REPORT**

**Date:** 3/22/2019 12:22:07 PM CST

**IRO CASE #:** XX

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** XX epidural steroid injection at the XX XX/XX level and XX XX/XX level

**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 reported that XX was XX a XX XX and was XX by XX-XX XX XX XX XX on the XX and was XX, XX XX for XX XX, saying XX was XX XX. XX had a XX above XX XX XX. XX was diagnosed with other XX with radiculopathy of the XX region (XX.XX), XX and XX XX of XX XX of the XX region (XX.XX), and chronic pain syndrome (XX.XX). XX evaluated XX. XX XX on XX for XX pain. XX. XX XX reported that a XX XX XX on XX XX and XX at a XX XX. XX sustained a XX and was told to put XX XX XX over the XX site. The ongoing XX pain was radiating down the XX XX into the XX XX and XX. XX intermittently had pain referred to the XX XX. The pain was increased and XX was unable to participate in the XX therapy at the time. XX was referred by XX specific targeting XX XX-XX and XX XX-XX level. The examination revealed tenderness over the XX and XX XX-XX and XX-XX

facets, positive XX referred in the XX XX region at the XX and XX nerve distribution and also referred XX XX at the XX distribution. There was 4/5 motor resting strength of the XX XX extremity, and +1 reflexes in the XX, XX, and XX XX. An MRI of the XX XX dated XX revealed XX-XX disc XX XX with impingement on the XX XX nerve root and XX-XX disc XX XX with impingement on the XX XX nerve root. Per a letter dated XX, an EMG study of the XX XX extremities revealed XX potentials in the XX XX extremity XX in the XX XX nerve root distribution consistent with XX XX nerve root irritation / injury. A few XX potentials were seen in the XX extensor XX XX XX, but not in other muscles in the XX XX extremity. This was a nonspecific finding, which could be related to the local muscle irritation / injury or nerve root irritation. Nerve conduction studies of the XX XX nerve were within normal limits although the baseline to peak amplitude of the sensory nerve action potential was less than XX XX. The peak-to-baseline amplitude of the XX XX sensory nerve action potential was within normal limit. The treatment to date consisted of medications (XX, XX #XX, XX, and XX) and a XX fusion at the XX-XX level in XX. Per the utilization review determination letter and Peer Clinical Review Report dated XX by XX, the request for XX epidural steroid injection at the XX XX-XX and XX XX-XX levels was non-certified. Rationale: "With regard to the XX epidural steroid Injection at the XX XX-XX level and XX XX-XX level, there was documentation of the injured worker having XX pain and previous imaging revealed a XX-XX disc XX XX with impingement of the XX XX nerve root and a XX-XX disc XX with impingement of the XX XX nerve root and the pain radiated down the XX and XX XX and the injured worker was not able to participate in XX therapy due to the pain and the plan to do this injection treatment. However, XX ESI treatment is no longer supported in the guideline criteria based on recent evidence due to serious risks of this procedure in the XX region and lack of quality evidence for sustained benefit. Therefore, this request is non-certified." Per an appeal letter dated XX, XX (XX) documented that XX had received a request for reconsideration (appeal) of an adverse utilization review determination. The clinical documentation available at the time of the initial utilization review request and any additional information submitted with the request for reconsideration would be provided to the practitioner conducting the appeal review. Appealed treatment / service request was XX / XX XX injection. Per a utilization review determination letter and Peer Clinical Review Report dated XX by XX, the request for XX epidural steroid injection at the XX XX-XX level and XX XX-XX level was non-certified. Rationale: "A prior request for XX XX-XX and XX XX-XX ESI was recommended non-certified. The provider has not provided any new clinical findings or compelling information to justify overturning the prior adverse determination. ODG does not support XX XX ESIs given a lack of efficacy and potential for adverse reaction. The provider has not provided any compelling information to justify deviating from guideline recommendations. If recommended, ODG requires definitive objective evidence of XX radiculopathy corroborated by MRI and / or EMG to support a CESI. The submitted records provide no documentation of XX, motor strength loss isolated to the targeted levels, XX or adverse nerve root tension to demonstrate XX radiculopathy. Moreover, EMG of the XX extremities did not demonstrate radiculopathy at either of the proposed target sites (XX-XX and XX-XX). As such, the request is not supported. Therefore, based on the lack of guideline support and lack of sufficient documentation to support this request, the request for XX epidural steroid Injection at the XX XX-XX level and XX XX-XX level is recommended non-certified."

**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 epidural steroid injection at the XX XX-XX and XX XX-XX levels.XX: XX epidural block XX: Fluoroscopic guidance for XX injection is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines note that XX epidural steroid injections are not recommended based on recent evidence, given the serious risks of this procedure in the XX region, and the lack of quality evidence for sustained benefit. The Official Disability Guidelines specifically note that injections should not be performed above the XX-XX level.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the decision

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