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[Date notice sent to all parties]:

03/08/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:1 XX transforaminal XX epidural steroid injection XX, XX, and XX between XX and XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Anesthesiology

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XX year old XX whose date of injury is XX. XX and a XX were XX a XX XX XX, XX XX XX to XX XX XX XX of the XX and XX an XX XX XX in XX lower XX that radiated into XX XX. Office visit note dated XX indicates that the patient presents with XX XX pain, pain to XX XX, pain to the XX XX and pain and numbness to the XX XX. The patient states XX continues to have severe XX XX pain that radiates to XX XX XX and XX XX. Pain is rated as 8/10. Current medications are XX and XX. On physical examination motor strength is -5/5 XX extremities and 4/5 to the XX extremities. There is severe XX XX tenderness over the facet joint areas, XX XX tenderness, XX SI joint tenderness, XX XX XX trigger points, tenderness over the XX XX area, XX PSIS tenderness, tenderness along the posterior aspect of the XX XX extremity. Range of motion is restricted and painful in all directions. Straight XX raising is positive at 30 degrees on the XX. There is decreased XX strength and decreased XX strength on the XX. Pinprick

sensation is decreased in the XX distribution of XX XX, XX and XX. XX and XX reflexes are diminished to the XX. Assessment notes XX disc displacement without XX, XX radiculopathy and XX radiculopathy. The initial request for XX XX epidural steroid injection XX, XX, and XX between XX and XX was non-certified noting that per guidelines, the purpose of epidural steroid injection is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, the reduction of medication use and the avoidance of surgery, but this treatment alone offers no significant long-term functional benefit. In this case, the patient complained of XX XX pain radiating to XX XX XX along with decreased pinprick sensation in the XX distribution of XX XX-XX. However, significant clinical findings presented were still limited to fully confirm radicular pathology as provocative tests and motor system test was not addressed. In addition, it was reported that XX received conservative care, but clear evidence of XX prior treatments was not fully established. Detailed objective evidence of a recent, reasonable and/or comprehensive non-operative treatment trial and failure should be considered prior to considering procedural levels of care. Lastly, XX epidural steroid injections, despite being generally regarded as superior to XX injections, are not significantly better in providing pain relief or functional improvement, according to a new systematic review. The denial was upheld on appeal noting that significant clinical findings presented were still limited to fully confirm radicular pathology as provocative tests and motor system test were not addressed. In addition, it was reported that XX received conservative care, but clear evidence of XX prior treatments was not fully established.

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 epidural steroid injection XX, XX, and XX between XX and XX is not recommended as medically necessary, and the previous denials are upheld. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. There are no imaging studies/electrodiagnostic results submitted for review. The Official Disability Guidelines also require that a patient is initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants, and XX drugs). There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There are no serial XX therapy records submitted for review. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE

IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES