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IRO REVIEWER REPORT

Date: 3/22/2019 1:20:13 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Diagnostic XX epidural steroid injection XX/XX on the XX X 1

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 is a XX-year-old XX who was injured on XX, when XX was XX in the XX XX and XX XX XX. XX experienced a muscle strain in the XX XX. XX was diagnosed with sprain of ligaments in the XX XX. On XX, XX. XX was evaluated by XX for a chief complaint of XX XX pain. The pain radiated into the XX XX extremity. XX was able to stand for more than XX minutes, able to sit for less than XX minutes, and able to walk for more than XX minutes. The pain level at the time was 7-8/10. The pain level at the worst was 9/10. Pain level at its best was 6/10. The pain was constant, burning, and cramping in nature with constant spasms. XX XX and medication made the pain better. There was no significant change since the prior visit. Examination revealed XX XX XX, diminished deep tendon reflexes in the XX extremities, positive straight XX raise test on the XX, and sensory deficit in the XX XX XX XX. XX. XX communicated a willingness for anesthesia during the procedure. XX had a degree of XX about XX. XX understood that it was important to minimize sudden movement during the procedure. XX expressed a XX and / or a XX impediment to not having a degree of XX medication while this procedure with XX was being performed. Per American Society of Anesthesiologists Guidelines, XX. XX was a candidate for monitored anesthesia care (MAC). The diagnosis of sprain of

ligament of the XX XX was established and diagnostic XX epidural steroid injection at XX-XX on the XX x1 was recommended. XX stated that the epidural steroid injection was denied despite meeting Official Disability Guidelines (ODG).

The MRI of the XX XX dated XX was positive for XX discs at XX-XX, XX-XX, and XX-XX. At XX-XX, there was a diffuse disc bulge measuring up to XX mm in the XX XX regions, which resulted in minor XX XX XX XX. At XX-XX, there was a diffuse disc bulge measuring up to XX mm, which resulted in mild XX XX XX XX. There were also XX XX XX XX XX. At XX-XX, there was a diffuse XX XX measuring up to XX mm.

An undated EMG was positive for radiculopathy on the XX at XX-XX, XX-XX, and XX-XX.

The treatment to date consisted of XX sessions of XX therapy, epidural steroid injection, massage, medication management, home exercise program, XX sessions of XX, and XX hours of chronic pain management program.

Per a Utilization Review dated XX, the request for diagnostic XX epidural steroid injection at XX-XX on the XX x1 was denied by XX. Rationale: “In this case, the patient presented with ongoing XX XX pain with radiation to the XX XX extremity. Imaging was positive for a XX disc at the requested level, as well as EMG was positive for radiculopathy on the requested level. Objective examination revealed diminished deep tendon reflexes, positive straight XX raising, and sensory deficit in the XX-XX XX, However, the requested XCPT code of XX indicated a request for anesthesia. Evidenced-based guidelines do not support the use of sedation during epidural steroid injections, as it remains controversial. Therefore, the request for diagnostic XX epidural steroid injection at XX-XX on the XX x1 is non-certified.”

Per a Utilization Review dated XX, the reconsideration request for appeal of diagnostic XX epidural steroid injection at XX-XX on the XX x1 was denied by XX. Rationale: “Official Disability Guidelines recommended epidural steroid injections as an option for the treatment of radicular pain when specific criteria are met. The guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and / or diagnostic testing. The patient must be initially unresponsive to conservative treatment, i.e., exercises, physical methods, and nonsteroidal anti-inflammatory drugs (NSAIDs) and muscle relaxants. The guidelines further state no more than one inter-laminal level should be injected at one session. If after the initial block / blocks are given and found to produce pain relief of at least 50 to 70 percent for at least XX to XX weeks, additional blocks may be supported. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. The patient has had XX previous epidural steroid injections (ESIs) and reported with the XX XX; there was a 40 percent improvement of pain symptoms. However, with the second ESI, there was no documentation of the patient’s response. There is insufficient documentation to support the need for an ESI. Therefore, the request for diagnostic XX epidural steroid injection XX-XX on the XX times one is not 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 Diagnostic XX epidural steroid injection at XX-XX on the XX x1 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 require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The submitted XX MRI fails to document significant neurocompressive pathology at the requested level. There is no XX XX or XX XX XX. There is no documentation of nerve root compression. The submitted clinical records fail to document adequate response to prior XX epidural steroid injections.

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