True Decisions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 5/10/2019 12:16:26 PM CST

True Decisions Inc.

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records – XX
- Request for XX Injection – XX
- Request for XX Injection Reconsideration – XX
- Medical Review – XX
- Adverse Determination – XX
- Appeal Determination Denial – XX
- Prospective IRO Review Response – XX
- Diagnostic Data Report – XX

PATIENT CLINICAL HISTORY [SUMMARY]: Xxxx. Xxxx Xxxx is a xx year-old xxxx with date of injury xxxx. The biomechanics of the injury was unavailable in the given medical records. On XX, Xxxx. Xxxx was seen by Xxxx Xxxx, MD for xxxx pain that radiated to the xxxx xxxx with ongoing tension on the xxxx. The pain was rated 2-5 on the numeric rating scale. On examination, there was limited range of motion noted for the xxxx xxxx and the xxxx region. Triggers were felt with XX XX in the xxxx side xxxx multifidus and xxxx side XX, upon palpation that produced twitch response with characteristic pain pattern An undated MRI of the xxxx spine revealed XX disc XX resulting in xxxx XX narrowing. Treatment to date included medications (Xxxx, Xxxx, Xxxx, Xxxx) xxxx xxxx multifidus trigger point injection, and xxxx xxxx surgery.Per an adverse determination / utilization review determination letter dated XX, XXXX XXXX, MD stated that “This XX -year-old patient sustained an injury on XX/XX/XX. The patient was diagnosed with a XXXX of ligaments of the xxxx XX, initial encounter. Per Official Disability Guidelines regarding xxxx XXXX steroid injections, "Not recommended based on recent evidence, given the serious risks of this procedure in the xxxx region and the lack of quality evidence for sustained benefit." In this case, the xxxx MRI revealed minimal pathology. There are no documented extenuating circumstances to support an exception to the guidelines. The request is not shown to be medically necessary. As such, the requested xxxx XXXX steroid injection under fluoroscopy at XX is denied.”Per an appeal determination denial / utilization review determination letter dated XX, XX , DO stated that “The Official Disability Guidelines state that xxxx XXXX injections are not recommended based on recent evidence, given the serious risks of this procedure in the xxxx region and the lack of quality evidence for sustained benefit. I spoke with Dr. Xxxx and discussed the case. It was reported that the patient failed conservative therapy and had MRI evidence of narrowing. There was also reports of trigger points. The patient complained of xxxx XX pain that radiated to the xxxx XX. On examination, limited range of motion of the xxxx XX was seen. There was also a positive twitch response in the xxxx XX. However, the examination on XX, failed to provide significant neurological deficits such as decreased motor strength and decreased sensation in a specific dermatomal or myotome distribution. Additionally, the guidelines state that epidurography is not routinely recommended. Lastly, the guidelines state that the injections are not recommended for the xxxx region. There are no extenuating circumstances that would warrant the usage outside of the guideline recommendation. As such, the APPEAL request is non-certified.”

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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 XXXX steroid injection under fluoroscopy at XX for the xxxx XX is not recommended as medically necessary, and the previous denials are upheld. Per an adverse determination / utilization review determination letter dated XX, XXXX XXXX, MD stated that "This XX-year-old patient sustained an injury on XX XX XX. The patient was diagnosed with a XXXX of ligaments of the xxxx XX, initial encounter. Per Official Disability Guidelines regarding xxxx XXXX steroid injections, "Not recommended based on recent evidence, given the serious risks of this procedure in the xxxx region and the lack of quality evidence for sustained benefit." In this case, the xxxx MRI revealed minimal pathology. There are no documented extenuating circumstances to support an exception to the guidelines. The request is not shown to be medically necessary. As such, the requested xxxx XXXX steroid injection under fluoroscopy at XX is denied." Per an appeal determination denial / utilization review determination letter dated XX, XX , DO stated that "The Official Disability Guidelines state that xxxx XXXX injections are not recommended based on recent evidence, given the serious risks of this procedure in the xxxx region and the lack of quality evidence for sustained benefit. I spoke with Dr. Xxxx and discussed the case. It was reported that the patient failed XX therapy and had MRI evidence of XX g. There was also reports of trigger points. The patient complained of xxxx XX pain that radiated to the XX. On examination, limited range of motion of the xxxx XX was seen. There was also a positive twitch response in the xxxx XX. However, the examination on XX, failed to provide significant neurological deficits such as decreased motor strength and decreased sensation in a specific dermatomal or myotome distribution. Additionally, the guidelines state that XX is not routinely recommended. Lastly, the guidelines state that the injections are not recommended for the xxxx region. There are no extenuating circumstances that would warrant the usage outside of the guideline recommendation. As such, the APPEAL request is non-certified." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines note that xxxx XXXX steroid injections are not recommended based on recent evidence, given the serious risks of this procedure in the xxxx 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 level. There is no significant neurocompressive pathology documented on xxxx MRI.
Given the documentation available, the request is upheld as the requested service(s) is considered not medically necessary 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:

☐ 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

XX XX: XXXX steroid injections (ESIs), therapeutic