I-Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd Ste B
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 790-2280
Email: manager@i-resolutions.com

Information Provided to the IRO for Review

- Utilization Review – XX
- Peer Reviews – XX
- Appeal of Adverse Determination – XX
- Attorney Letter – XX

Patient Clinical History (Summary)

XXXX. XXXX XXXX is a XXXX-year-old XXXX with date of injury XXXX. The injury occurred when XXXX was pulling XXXX up a XX and injured XXXX XXXX XXXX and XXXX. XXXX was diagnosed with XXXX pain XXXX, unilateral primary XXXX (OA) of the XXXX XXXX, XXXX XXXX pain, and long-term XXXX use.

Per the physician review recommendation clinical summary dated XX, it was documented that a peer review dated XX non-certified the request for XXXX XXXX steroid injection. The rationale for non-certification indicated that XXXX XXXX x-rays were ordered, but there was no formal report. Furthermore, the only findings on examination were tenderness to palpation over the XXXX XXXX line, medial XXXX line, and XXXX. Per the office visit note dated XX by XX XX, NP, XXXX. XXXX complained of pain in the low XXXX and XXXX XXXX. XXXX reported feeling shock in the XXXX XXXX and that XXXX XXXX injection in XX provided 90% relief. XXXX examination findings included global antalgic XXXX, slowed XXXX, stooped XXXX, a positive XXXX straight leg raise (SLR) test 30%, confirmed dorsiflexion at XX, decreased sensation to light touch and pinprick in XXXX, motor diminished XXXX plantar and dorsiflexion, and weakness with XXXX pushups and XXXX XXXX.

The treatment to date consisted of medications (XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX), XXXX XXXX injection on XX (90% relief), XXXX XXXX injections (TPIs), XXXX therapy, XXXX XXXX program, XXXX anti-inflammatory drugs (NSAIDs), and surgical interventions XXXX and XXXX XXXX at XXXX and XX-XXXX with removal of instrumentation resulting from an injury on XXXX, XXXX XXXX implantation in XX with removal in XX, total XXXX replacement in XX and revision in XX, implantation of a XXXX XXXX XXXX XXXX and complex programming of the XXXX XXXX XX on XX.

Per a utilization review determination letter dated XX, a request for XXXX XXXX steroid injection was non-certified by XXX, MD. Rationale: “In this case, the provided documentation provides limited objective information regarding the XXXX and it is unclear why this procedure would require to be repeated less than three months from the initial injection. As such, this request should not be considered medically necessary at this time. The Official Disability Guidelines have been referenced in this case. The Guidelines state following several months of temporary, partial resolution of symptoms, then recurrent worsening pain, a repeat steroid injection may be an option, although the potential risks should be specifically discussed. In this case, the provided documentation provides limited objective information regarding the XXXX and it is unclear why this procedure would require to be repeated less than three months from the initial injection. As such, this request should not be considered medically necessary at this time.

Per a physician review recommendation dated XX, an appeal for XXXX XXXX steroid injection was XX by XX, MD. Rationale: “The XXXX and leg chapter of the ODG states regarding XX injections, "Recommended as indicated below. Intra-articular XX injection can result in marginal but statistically significant pain reduction for XXXX XXXX, with effects lasting up to 6 months. Due to recently proven time- and dose-related XX effects of XX, which are further worsened by the addition of local anesthetics, injection intervals should be a minimum of 4 months (preferably 6-12), and lowest doses should be utilized. Extended-release XX is not yet recommended pending further study. Criteria for intraarticular XX injections: Lowest doses of XX should be used. Intra-articular XX and XX should be minimized or avoided (saline OK for dilution) due to additional XX. Documented symptomatic severe XXXX of the XXXX according to American College of Rheumatology (ACR) criteria, which require XXXX pain and at least 5 or the following: (1) Bony enlargement; (2) Bony tenderness; (3) Crepitus (noisy, grating sound) on active motion; (4) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr; (5) Less than 30 minutes of morning stiffness; (6) No palpable warmth of synovium; (7) Over XX years of age; (8) Rheumatoid factor less than 1:40 titer (agglutination method); (9) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3); Failure to adequately control symptoms with recommended conservative treatments (XXXX, NSAIDs, or XX); Pain interferes with functional activities (e.g., ambulation, prolonged standing) and cannot be attributed to other forms of XXXX disease; intended for short-term control of symptoms to resume other conservative medical management or delay TKA; Generally

performed without fluoroscopic or ultrasound guidance; Absence of synovitis, presence of effusion preferred (not required); Aspiration of effusions preferred (not required); Only one injection should be scheduled, not multiple; A second injection is not recommended if the first has completely resolved symptoms or if there was little or no response; Following several months of temporary, partial resolution of symptoms, then recurrent worsening pain, a repeat steroid injection may be an option, although potential risks should be specifically discussed; The number of injections should be limited to three over a 12-month period (preferably one or two); TKA should be delayed a minimum of 6 months following any intra-articular XX XXXX injection; Prior to injection, patients with XX should be advised that blood glucose may be elevated for up to a week after XX injections." The injured worker had a prior injection in XX XX that provided 80% improvement in pain. The guidelines require documentation of severe XXXX based on nine criteria. However, the clinician has provided no XXXX exam findings of the XXXX XXXX to warrant a repeat steroid injection. With the absence of XXXX exam findings of the XXXX XXXX, the request for XXXX XXXX steroid injection is denied and the prior determination is upheld on appeal."

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

This patient XX and XXXX XXXX stimulation. There is limited documentation from the provider who is requesting a XXXX XXXX steroid injection. There is a diagnosis of XXXX in the patient's summary, but X-ray evidence of XXXX XXXX XXXX is lacking. There are no X-ray reports. The patient had a steroid injection in the XXXX XXXX in XX XX which produced 90% relief for an unknown injection. So, it is not unreasonable to request a second injection if the duration of the relief following the injection was significant. A Utilization Review in XX XX stated "the provided documentation provides limited objective information regarding the XXXX and it is unclear why this procedure would require to be repeated less than three months from the initial injection." This assessment is accurate. Another review in XX XX "The injured worker had a prior injection in XX XX that provided 80% improvement in pain. The guidelines require documentation of severe XXXX based on nine criteria. However, the clinician has provided no XXXX exam findings of the XXXX XXXX to warrant a repeat steroid injection. With the absence of XXXX exam findings of the XXXX XXXX, the request for XXXX XXXX steroid injection is denied and the prior determination is XX on appeal." This assessment is also accurate. The clinical documentation in this patient is very limited, and so, it is very difficult ascertaining whether the guidelines are met. Given the documentation available, the requested service(s) is considered not 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
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of XXXX Low XXXX 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
- ☐ 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 XXXX 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.