C-IRO Inc.

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

XX XX-XX and XX-XX transforaminal epidural steroid injection, XX approach with a catheter, additional levels, moderate sedation, and under fluoroscopic guidance.

XX: Injection, XX, epidural, XX
XX: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance; XX or XX
XX: Moderate (Conscious) sedation
XX: XX for XX injection

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Anesthesiology

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

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX. XX XX is a XX-year-old XX who was primarily diagnosed with XX XX (XX.XX). The secondary diagnoses were chronic pain syndrome, sprain of unspecified collateral ligament of XX XX, XX syndrome, and XX of the XX region.

On XX, XX. XX was evaluated by XX XX, XX for the primary complaints of XX XX pain. XX was previously seen on XX where XX injection was administered intramuscularly. XX reported good relief with injection, which lasted for XX days. At that time authorization for XX epidural steroid injection was sent out and was pending for peer to peer. XX complained of moderate to severe XX XX pain, radiating down XX XX XX with numbness. The pain was rated as 1-2/10 and described as shooting, aching, dull, stabbing, burning and tingling. The pain worsened with increased activity such as driving, prolonged standing, walking, bending, lifting and sitting for long periods of time. Pain was better with rest, lying down, applying heat and pain medications. XX XX quality was poor. The XX XX examination showed midline tenderness to palpation over the XX-XX levels with decreased range of motion to XX flexion / extension and rotation secondary to pain. The sensation was decreased to light touch at the XX XX XX XX and XX XX with positive straight XX raise at 60 degrees for radicular pain. Also, there was decreased sensation to light touch at XX XX XX XX and XX XX.

CT scan of the XX XX dated XX showed XX XX-XX and XX-XX moderate / severe XX narrowing. XX XX screw fracture was seen. CT scan of the XX XX dated XX revealed surgical XX XX at XX-XX. Interbody XX appeared solid, though not XX elements. There was also a fracture of XX XX anchoring screws. Multilevel XX most notable at XX-XX with XX XX compromise. X-ray of the XX XX showed status post fusion at XX-XX with fracture of anchoring XX screws of XX XX, there was mild anterior XX at XX/5 that is stable on the flexion/extension views, diffuse XX was noted and XX XX XX was present.

Treatment to date included medications (XX, and XX), XX injection, intramuscularly, transforaminal epidural steroid injection (provided 80% pain relief), and surgical intervention (unspecified XX surgery, XX XX, permanent XX XX XX with generator revision).

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Notice of Independent Review Decision

Case Number: XX Date of Notice: 05/01/19

Per utilization review determination letter by XX XX, XX dated XX the request was not certified. It was determined that per Official Disability Guidelines XX XX chapter, XX epidural steroid injection for treatment of XX XX pain with radiculopathy were recommended as adjunct therapy intended to enable or better enable patient participation in active rehabilitation efforts. XX. XX previously had XX epidural steroid injection, however, there was no evidence that XX had received qualifying benefits from those injections, as required by the Official Disability Guidelines. Moreover, there was no indication that XX. XX had trialed and failed conservative therapies such as non-steroidal anti-inflammatory medications (NSAIDs) or neuropathic pain medications, or engagement in active rehabilitation efforts. Compliance with the Official Disability Guidelines and medical necessity were not established by the information in the available medical records. Thus the request for XX XX-XX, XX-XX transforaminal epidural steroid injection, XX approach with catheter, additional levels, moderate sedation, under fluoroscopic guidance was non-certified.

A letter dated XX indicated that the reconsideration request was denied. Rationale: "The current request is for a repeat XX epidural steroid injection (TFESI) but there is no indication on what date(s) any prior injections occurred nor how effective they may have been. ODGs refer to "conservative care prior to a diagnostic injection", but this would be considered a therapeutic injection for which ODGs "recommend 50-70 percent improvement over XX weeks". Such a response, in this case, is unknown and while the circumstances preceding this request may, in fact, coincide with such recommendations, in the absence of such information, this request cannot be determined to be medically necessary or appropriate. Therefore, the requested APPEAL XX XX-XX, XX-XX transforaminal epidural steroid injection, XX approach with catheter, additional levels, moderate sedation, and under fluoroscopic guidance XX XX XX XX is not medically necessary and is upheld."

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

The diagnosis in this patient is thought to be either a XX XX or XX-mediated pain. The examination is unfortunately vague and other than mild tingling in the XX, there are no other signs of nerve damage secondary to disc XX. The MRI shows some XX XX without the presence of XX disease, but also some facet XX. Two prior utilization reviews correctly interpreted the findings and were unable to find guidelines that would justify the ESI or warrant going outside the guidelines. 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 Chronic Low XX 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 XX 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.