Magnolia Reviews of Texas, LLC
PO Box 348
Melissa, TX 75454
972-837-1209 Phone 972-692-6837 Fax
Email: Magnoliareviews@hotmail.com

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

MD, Board Certified Pain Medicine.

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]:

XXXX. XXXX has not had any XX XX. XX evaluation dated XXXX indicates that the patient had a previous XX XX XX trial and implant about XXXX. XXXX trial was successful enough to go forward with XX, but XXXX had to turn the XX up very XX to cover the XX and XX and this caused XX pain in the XX and XX and XXXX was XX to walk. Per the office visit dated XXXX, the patient presented for follow up of pain in the XX XX, XX, and XX. The XX pain was described as XX, XX, and XX of any movement. The pain was rated XX/10 at the time of the visit, XX/10 with medications, and XX/10 without. Comfort level and functional status were XX. It was noted XXXX was status post XX XX XX XX XX lead and XX XX done by another provider on XXXX. The patient reported the XX XX XX covered all of the XX pain and most of the XX except the constant XX pain. The conventional XX XX XX was used for XX pain and XX pain, but when XXXX tried to turn it up to cover the XX better, it made the XX pain worse. XXXX reported the only relief XXXX could get was to take XXXX, sit down, and elevate the XXXX leg. XX was extremely difficult. XXXX reported moderate relief and no side

effects with the current medications. Current medications included XXXX. Medical history included a XX XX in XX areas with the development of XX into the XXXX XX, XX, XX, and XX of the XX. This caused XX XX and XX and XX XX. XXXX had a XX injury and a XX XX. Physical examination of the XX XX noted tenderness to palpation of the XXXX XX joint. Examination of the XXXX XX noted active XX to XX degrees. Sensation was decreased to XX touch on the XXXX at XX. Motor testing noted XX/5 reduced XX strength of the XXXX XX XX and XX/5 strength/minimal contraction of the XXXX ankle XX and XX. XX favoring the XXXX XX was noted. The assessment included XX pain due to XX. The treatment plan included a XX trial, XXXX XX and XX XX trial, to see if this could better relieve the XXXX isolated XX pain and follow up in XX month. Office visit note dated XXXX indicates that the patient is seeking medication refills for XX pain. Current regimen includes XXXX. The patient got a XX XX and reports that XXXX is able to XX now with XXXX XX elevated and is XX better and was able to XX all XX and XX up with less pain in XXXX XX. Pain with meds is rated as XX/10. On physical examination strength is XX/5 in the XXXX XX XX with the exception of XX/5 XXXX XX extensors and XXXX XX flexors. XXXX XX XX strength is rated as XX/5. Deep XX reflexes are XX/2 XX. Straight leg raise is XX XX.

Determination letter dated XXXX indicates that the reviewer does not recommend approval for the requested services as reasonable or medically necessary. There is no extent of objective measured functional benefit from previous XX XX XX use. No report is provided regarding type and extent of comprehensive conservative based treatment including attempted recent physical therapy, home exercise program, non-XX medications including muscle relaxants, XX, XX agents, or topical agents as well. Determination letter dated XXXX indicates that the patient recently underwent a XX XX XX implantation which covered the majority of XXXX XX and XX symptoms. However, there was noted to be persistent XXXX XX and XX pain, which was noted to be reduced by XX% with the use of XX. Additionally, the patient had examination findings consistent with XXXX XX XX dysfunction and XX testing consistent with XX and XX referral patterns. There does not appear to be any evidence of a diagnostic XXXX XX joint or XX selective XX block having been performed that would suggest the medical necessity for a XX trial at this time.

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 XX XX trial XXXX XX and XX is not recommended as medically necessary. The submitted records fail to establish that the patient presents with a diagnosis for which guidelines would support XX trial. The submitted records indicate that the patient has had no previous XX surgery. The Official Disability Guidelines support XX trial only for diagnosis of failed XX XX syndrome or XX. Additionally, there is no documentation of any recent active treatment. 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

XX