Applied Independent Review

An Independent Review Organization

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Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:
Neurological Surgery

Description of the service or services in dispute:
Placement of XX via XX of XX and XX stay for the XX.

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:
- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)
XXXX. XXXX. XXXX. The ongoing diagnoses included XX, XX, and XX XX pain.

Per an office visit, XXXX as a XX patient for XX syndrome. XXXX had begun to develop very XX XX pain. XXXX saw XXXX who did a trial of XX therapy with the XX, which significantly improved both of XXXX pain complaints. XXXX presented to discuss XX of the XX. Examination findings were unremarkable.

XX dated XXXX showed mild XX XX XX at XX and XX without significant XX XX, mild XX XX XX at XX and XX XX at XX.

The treatment to date included work modifications, diagnostic studies, XX, XX, XX XX injections, XX therapy, XX, XX, and a XX trial placement.

Per an Adverse Determination letter dated XXXX opined the request for XX stay with XX of XX via XX XX for the XX at XXXX as requested by XXXX at XXXX was denied.

Rationale: “The Official Disability Guidelines state XX XX requires evidence of XX% pain relief and medication reduction or functional improvement after temporary trial. In this case, the patient had a XX and reported XX therapy significantly improved both XXXX pain and complaints. The XXXX progress note was illegible but noted the patient had improvement in XX, XX, and XX XX pain. The percentage was "XX%". This percentage should be clarified prior to permanent placement.”

Per an Appeal Determination Denial letter dated XXXX, the appeal for placement of XX via XX and XX stay for XX at XXXX as requested by XXXX at XXXX was denied. Rationale: "This is a noncertification of an appeal of a XX placement XX and placement of a XX with an observation stay. The previous noncertification on XXXX, was due to lack of improvement with the XX trial. The previous noncertification is supported. Additional records were not submitted. The guidelines would not support XX XX without XX relief including medication reduction and functional improvement. The patient was evaluated in XXXX; however, this did not include objective documentation of decreased pain scores, decreased medication requirement, or improved function with XX. The request for an appeal of a XX placement via XX with an XX stay is not certified." Physician Advisor attempted a peer-to-peer telephone conversation with XXXX on XXXX. Physician Advisor noted the XX% pain relief, but also noted that objective documentation was needed to support the percentage of relief.

On XXXX, XXXX wrote a letter stating that XXXX came for the first time with a chief complaint of chronic pain after XXXX suffered an injury XXXX. XXXX underwent a XX of XX, which had not provided XX relief. XXXX ultimately had a XX done by XX.

XXXX, pain management XX, which was successful. XXXX got over XX% pain relief in a XX trial. Unfortunately, two requests that had been submitted for authorization, had been denied. The doctors doing the peer-to-peer reviews had called XXXX when XXXX was in XX, but XXXX had called them back and they never returned XXXX calls. XXXX thought there was enough documentation about how successful the trial had been, so XXXX was asking to reconsider the request. XXXX had been performing the operations for several years and had treated numerous patients with XX pain. XXXX opined that it was medically necessary as the patient was in XX pain and the trial was successful. XXXX had discussed with XXXX the risks and benefits and XXXX was desperate to go forward with the proposed XX.

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

The claimant has been followed for a history of chronic XX pain. While the claimant did report improvement with a XX trial, the specifics regarding the outcome of the trial were unclear. There was no indication XX or medication reduction during the trial period. Further, the records do not indicate that the claimant meets the requirements for XX XX. While there is evidence of XX pain, the claimant's symptoms and physical exam findings are not consistent with an XX condition. The claimant also did not have a prior XX history for XX that would support a diagnosis of post-XX XX or XX syndrome.

Given these issues which do not meet guideline recommendations for a XX implant, it is this reviewer's opinion that medical necessity for the request is not established and the prior denials are upheld.

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

- [ ] um knowledgebase AHRQ-Agency for Healthcare Research and Quality
- [ ] Guidelines

DWC-Division of Workers Compensation

- [ ] Policies and Guidelines European Guidelines for
- [ ] Management of Chronic Low Back Pain
- [ ] Interqual Criteria
- [x] 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

- [x] 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 Médical **Literature** (Provide a description)

Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)