Icon Medical Solutions, Inc.

P.O. BOX 169
Troup, TX 75789
P 903.749.4272
F 888.663.6614

DATE: 9/24/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX and Supplies, XX Support

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer specializes in Physical Medicine/Rehabilitation and has over 25 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ 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: Progress Report by XXXX. Patient presents with symptoms beginning in XXXX. This is caused from a work related XXXX. Pain stiffness/tightness, aching, burning, cramping and radiating. Pain is continuously. Symptoms area located in XX XX and XX. Pain radiates down the XX. Pain is aggravated by bending, lifting, standing, walking and twisting. Pain is improved by nothing. Pain is associated with numbness, weakness and poor sleep. Patient experiences numbness/tingling in XX. Good compliance with medical regimen. Medication provides 80-90% relief. Pain is unchanged since last visit. Pain is 8/10 max, 9/10 max. Medications that have been used include narcotics, antidepressants, muscle relaxants, NSAIDs, XXXX. Treatments have included ESI's. No pharmacologic approaches have been used include acupuncture, chiropractic's, massage, physical therapy, psychotherapy, XX. Medications help. Physical therapy has (Not Applicable). The HEP has (Not Applicable). Pt has exacerbation due to none. Weakness has remained the same. Numbness/tingling have remained the same. Overall, the patient is feeling the same. Pain has remained the same. Parasthesias numbness/tingling, XX. XX-yes, XX. XX-yes. XX, XX, XX- yes. Current Medications- XXXX. Physical Examination: XX XX- XX tenderness. AROM shows the pt is able to forward flex at the waist, with severe limitation, with pain at the XX XX XX, with pain down the XX leg. Palpation- rt paraspinal tenderness. XX- decreased. Sensory Exam- normal XX XX. Gait- slouching XX. XX XX- ROM neck: limited in all directions. Reflexes- 2 XX. Sensations-

normal XX. Tenderness- XX. Assessment- 1. Failed XX syndrome of XX XX. 2. XX with XX. 3. Acquired XX of XX region. Plan- Refill XXXX. Pt need to be on long-term tx with narcotics due to fail with alt tx methods. (D/W re: poss addiction); D/W re: LS MRI; poss L4/5-epi; rx for XX unit supplies for neuropathic pain XX leg.

XXXX: UR by XXXX. Rationale- Denied. A peer to peer discussion was unsuccessful despite calls to the doctor's office. The guidelines do not recommend XX unit as an isolated intervention; however, the guidelines state a one-month home-based XX trial may be considered as a XX option for chronic XX pain, if used as an adjunct to a program of evidence-based conservative care to achieve functional improvement measures, including reductions in medication use. From the record, the pt has chronic pain in her XX XX. Documentation was unclear as to if the request was for a trial or a purchase for the XX unit. In addition, documentation was unclear as to if the patient will be using the XX as an adjunct to a program of evidence-based conservative care. Without that information, the request is not supported.

XXXX: UR by XXXX. Rationale- Treatment plan included continuation of medication management, an MRI of XX XX, a XX unit and supplies and a follow-up in 4 weeks. Prior treatment included medication management, acupuncture therapy, chiropractic therapy, massage therapy, physical therapy, psychotherapy, a XX unit, and activity modification. A peer to peer discussion was unsuccessful. According to documentation, pt had low XX pain that radiated into her XX XX extremity. On examination, she had severe limitations with ROM and tenderness to XX muscles. Decreased motor strength. The request does not specify how often the unit was used as well as outcomes in terms of pain relief and function. This request does not specify if the unit is for rental or purchase. There was no evidence that the pt will be using a XX unit as an adjunctive treatment to a program of evidence-based functional restoration. As such, the request is not supported. Regarding the request for XX XX XX support, the submitted documentation did not prove evidence of instability on examination of the XX XX to support a XX for this patient. There were no exceptional factors provided for review to support this request beyond guideline recommendations. As such, this request is not appropriate for this patient.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse decisions are Upheld. There is lack of clinical information. There is question as to the results of a 30 day trial of a XX unit, particularly the frequency and duration of daily use, quantifiable decrease in consumption of analgesic medications, and quantifiable/exemplary increase in functional activity. There is question as to documented XX instability. There is also question as to trials of past bracing including frequency and duration of use, and compliance with adjunctive home exercise program so as to avoid deconditioning of XX, and results of those trials in terms of quantifiable decrease in consumption of analgesic medications, and quantifiable/exemplary increase in functional activity. With regard to both requests, given the chronicity of this case for XXXX years, there is also question as to compliance with other self-directed pain modulation techniques including a Home Exercise Program, physical modalities such as heat/ice, over the counter oral/topical medications, relaxation/pain management techniques, sleep hygiene and activity modification. Therefore, the request for XX Unit and Supplies, XX is considered not medically necessary.

PER ODG XX

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**

☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW XX PAIN**

☐ **INTERQUAL CRITERIA**

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**