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Date: 10/XX/2018 and Amended 10/12/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX XX trial, XX

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

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a XXXX with a history of an occupational claim from XXXX. The available documentation did not provide evidence of a mechanism of injury. XXXX was diagnosed with low XX pain, radiculopathy of the XX region, XX stenosis of the XX region, XX, XX stenosis of the XX region, other XX XX degeneration of the XX region, and other XX XX displacement of the XX thoracic region. On XXXX, the patient presented for follow-up. XXXX previously underwent XX XX-XX, XX-XX epidural injections, and reported XX% relief from the procedure. His pain level was rated 8/10, and XXXX was requesting medication refills. The pain was located in the low XX, radiating down the bilateral XX extremities, and in the XX XX, radiating to the XX XX and shoulders. XXXX had a history of XX XX surgery. On examination, straight leg raise was positive XX. The patient ambulated with an antalgic gait. There was tenderness over the midline in the XX XX, with painful range of motion noted. Sensation was diminished in a XX XX through XX distribution, and in the XX XX-XX distribution. The treatment plan included medication refills. The patient was also recommended for a XX XX XX given the history of low XX pain, prior XX surgery, and radiculopathy. A psychological evaluation was performed on XXXX, indicating that the patient did not have any contraindications to a XX XX XX. However, the requested XX XX XX trial was denied as there was no indication that the patient was not a candidate for repeat surgery, and the patient had a significant response to recent injections, and guidelines require limited response to non- interventional care.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS,

FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Regarding the requested XX XX XX trial for the XX XX, evidence-based guidelines indicate that XX XX stimulators may be indicated for patients with failed XX surgery syndrome, who failed to respond to XX levels of care. XX XX stimulators may be used and there are no other alternatives of treatment. In this case, the request was previously denied as the patient had responded well to injections and medications, and there was no indication that the patient was not a candidate for further surgical intervention. There was insufficient documentation to support the returning the previous denial.

As such, XX XX XX trial for the XX XX is not medically necessary, and the prior determination is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Low XX, XX XX stimulation (SCS).... Recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated.....See the Pain Chapter for Indications for XX implantation. See also Psychological evaluations (SCS) in the Mental Illness and Stress Chapter.....For average hospital LOS if criteria are met, see Hospital length of stay (LOS).