Date notice sent to all parties: 4/11/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of a repeat XX XX trial.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in Anesthesiology.

REVIEW OUTCOME:

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a repeat XX pump trial.

PATIENT CLINICAL HISTORY [SUMMARY]:
Patient is a XX year old XX who injured XX XX XX XX on XX. XX had a XX injury and underwent XX XX XX XX (XX) which never healed XX, and XX developed complex regional pain syndrome (CRPS). XX had an XX XX trial on XX. XX was not interested in another trial but wanted XX therapy. A repeat XX XX trial was requested for the XX XX XX. Patient was recently status post XX XX to the XX XX due to instability. XX has attended XX therapy and had a XX XX XX block with 20% relief for about XX XX. XX underwent a XX XX XX trial as well. XX has ongoing symptoms including XX, decreased temperature, weakness and trophic changes with limited use of the XX. The duration of the XX trial that was done is unknown.

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

Per evidence-based guidelines and the records submitted, this request is non-certified. Per ODG criteria for a trial of an XX pain XX requires that XX-XX oral medication regimens have been tried and have failed to relieve pain and improve function and there has been documented improvement in pain and function in response to XX medications, but intolerable adverse effects preclude their continued use. The claimant is taking XX XX-XX every XX hours and XX XX every XX hours. XX reports that these medications help relieve XX pain to a tolerable level and increases activities of daily living (ADLs). XX also confirms there are no side effects. There is no indication to transition this claimant to an XX pain XX. XX XX equivalent dose (XX) is only XX. While it is noted that XX has failed XX, XX, XX and XX, the injured worker appears to be tolerating XX well and there is no indication XX has failed long-acting XX or long-acting XX. This injured worker does not meet ODG criteria for an XX pain XX trial. As such, this request for repeat XX XX trial for the XX XX XX is not medically necessary.

Recommended only as an end-stage treatment alternative for selected patients for specific conditions indicated in the blue criteria below, after failure of at least XX months of less invasive methods, and following a successful temporary trial. Indications for XX XX-XX XX:
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 BACK 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)**