Date notice sent to all parties

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
X

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 Orthopedic Surgery.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Records were received and reviewed from the following parties: X Consultants and TDI IRO Assignment

These records consist of the following (duplicate records are only listed from one source): Records reviewed from X Consultants:
X Consultants:
Progress Notes-X
DME Script-X
X Health Center:
MRI Report-X

Records reviewed from TDI IRO Assignment:
X International:
Denial Letters-X
X Consultants:
Utilization Review General PA Form-X

Progress Note-X
Urine Drug Screen-X

Optum:

Utilization Review Referral-X

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a X-year-old X who sustained an X injury on X. The mechanism of injury was described as. X underwent X in X complicated by a X injury resulting in X in the X extremity. The X MRI impression documented post-operative changes at X suspected. There was X, contributing to X. There were degenerative changes at X. The X pain management progress note cited complaints of grade X pain that was worse with X and better with X. X reported X. X reported some increase in pain attributed to X. X was severely limited in X functional capacity, but medications allowed some activities of daily living and improve quality of life. X was ambulating X. X had not had prior relief with X or X. Progress report documented body mass index of X. X exam documented decreased, well-X, XX to the X, muscle X and X, X, decreased X, positive X test, and X. Neurologic exam documented decreased X extremity and X extremity sensation, decreased X extremity strength due to pain, and diminished X reflexes. The diagnosis was documented as X and X syndrome. The treatment plan recommended continued medications including X. The X pain management progress note cited complaints of constant grade X pain. X reported decreased pain with new X. X had lost some weight and felt better overall. X was stable on current medications. X asked about a X. X and X exam findings were unchanged from X. Medications were continued unchanged from X. X was to continue X. A X was ordered. The patient would use the X to reduce pain by X and otherwise support X, and would use the X during strenuous activities. Authorization was requested for purchase of a X for a diagnosis of X. This particular X is described as a X. The requested CPT codes X describe a pre-fabricated X that produces intracavitary pressure to reduce load on the X. Purchase price was X. The X utilization review determination indicated that the request for purchase of an X was non-certified. The rationale stated that the Official Disability Guidelines do not recommend X supports for prevention and there was no evidence of specific X being present that might be amenable to treatment with a X. It was unclear what had prompted consideration of a X for this patient. The X pain management progress note cited complaints of grade X pain. The patient was doing better with X and stable on current medications. X was asking about a X. X and X exam findings were unchanged from X. The treatment plan recommended continued X and X. It was noted that peer-to-peer was pending for the X. The X utilization review determination indicated that the appeal request for purchase of an X was non-certified. The rationale stated that there was no evidence of recent surgery or documented instability to support this request. Furthermore, the patient

presented with a history of X pain and there were no exceptional factors to support use outside of guidelines.

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

The Official Disability Guidelines state that X supports are not recommended for prevention. There is strong and consistent evidence that X supports were not effective in preventing X pain. X supports are recommended as an option for X and specific treatment of X, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). The Official Disability Guidelines do not specifically provide recommendations for X. Guidelines do not recommend X which were designed to potentially provide support-stabilization and X as there was minimal evidence to support the use of this device at this time. A review of PubMed for evidence based medical literature for this type of X did not show any current literature. A review of the clinical studies section of the manufacturer's web site revealed patient surveys and case reports.

This patient presents X. X is reported to be severely limited in X functional capacity. Current medications allow some activities of daily living and improve quality of life. Pain has recently reduced with X. Under consideration is a request for purchase of an X. The particular X prescribed produces XX X to reduce load on the X. It is reported that the patient would use the X to reduce pain by restricting X and otherwise support, and would use the X during strenuous activities. There is no particular rationale to support the current addition of this type of X at this time for X injury. There is no documentation of recent X instability. There is no compelling rationale to support the medical necessity of X over exercise to address X weak X. There is no evidence of planned strenuous activities given that this patient is reported to be severely X. There is no specific indication to support the medical necessity of this type of specialized X. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines. Therefore, this request is not medically necessary.

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)**