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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

TDI:

- Notification of Adverse Determination (X)

XX:

- MMI/IR evaluation (X)
- Office visits (X)
- Utilization review referral (X)
- Notification of Adverse Determination (X)

XX XX, D.O.:

- Procedure note (X)
- Office visits (X)
- Diagnostics (X)
- Notification of Adverse Determination (X)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X year-old X who was injured on X. X was working X. The X had been discontinued from the X. The patient X. X did recall having been found "X." X impacted the X on something in X.

On X, X, M.D., performed a X, XX stabilization X.

On X, X, D.O., performed a maximum medical improvement (MMI)/impairment rating (IR) evaluation. Dr. X assessed the patient had reached MMI on X, with X whole person impairment for compensable injuries. If the disputed conditions including X, X were found to be compensable, then the MMI date would be affected. There was no evidence that the injury, medications or subsequent treamtent were respondisble for X.

On X, the patient was seen by X M.D., for reevaluation injuries sustained on X. The patient had undergone X following injury. X presented with an approximately X months history of progressive worsening of X pattern. The worsening factor included prolonged X. The X X up X per night

essentially every night. The X examination revealed persistent X. The spasms were present from X. The X. The X was maintained in the X device. The assessments were X, status post X instrumented X, X, X following X. X was prescribed. The plan was to refer to X, M.D., for evaluation for the possibility of X -based modalities as appropriate.

On X, the patient was seen by X, D.O., for initial pain evaluation of chronic X pain. X reported occasional X. The pain was escalated to X associated with X. The patient presented with constricted affect and X. X tried NSAID in the form of X with mixed results. The X pain continued despite conservative X care. X had undergone numerous drug regimens of X therapy. The self efficacy scores were X and the patient had a moderate risk factor for XX use. X admitted to X. X also admitted to X. The physical exam revealed a limited range of motion of the X approximately X of normal and trigger pint throughout the X. DTR's were 1+X. The X was X degrees and extension was degrees. There were mild trigger points extending from the X area. X had X degrees X without stretch-stress signs. The diagnoses were X pain syndrome status post surgical intervention with hardware following X and work injury, X pain with X pain syndrome and daily X following X injury and X and moderate reactive X state. X were prescribed. The trigger injection therapy for jump signs elicited in the X area associated with functional restoration, improvement, affect and sleep should provide a solitary benefit. X versus X therapy might be reserved for X pain.

On X, the patient was seen by Dr. X for follow-up of pain in the X region. X reported some progress. The affect and X pain had improved. X also had moderate X pain as well as X tenderness. X was noted to have exquisite tenderness over the X area, tightness from X mostly on the X with extreme jump signs, extreme X and extreme pain with passive and active ROM. Current medications were X TID, X in the morning and X at night. The recommendation was to proceed with X for jump signs which were X therapy.

On X, the patient was seen by Dr. X for follow-up of pain in the X region. The affect had improved with a combination of X and XX had been stabilized with X X had failed conservative rehabilitative medical treatment options. The jump signs were elicited. The patient had Mx pain across the X. The X therapy was recommended due to improved X.

On X, Dr. X administered X around the instrumentation and X.

On X, the patient was seen by Dr. X for complaints of difficulty holding the X of injuries. The current medications were X. X was also taking X but was only using that medication about two to three days out of the week. Regarding X pain, X had a X which showed positive efficacy with the X. The patient was referred for X consultation.

On X, the patient was seen by Dr. X for severely increased X pain for over a month. The pain was located in the X down to slightly below the X tips. X did not report any X. The X pain had been resistant to resolution with home stretching exercises or use of X, both of which have previously provided a significant positive benefit. The back exam revealed prominent X activity approximately equally distributed between the X almost exquisitely over X level. The patient was referred to Dr. X for further evaluation.

On X, the patient was seen by Dr. X for pain in the X region. X was noted to have excellent relief of pain, improved function and decreased medications from the X over a year ago. With increased work activity of around X hours, X is getting pain in the X in the X regions. X had failed conservative PT and rehabilitative care. The jump singes were elicited just outside the prior X surgery including X from X. The plan was to schedule a X therapy.

On X, urine drug screening was X.

On X, a Utilization Review Referral was requested by Dr. X.

On X, Notification of Adverse Determination was documented based on the review by X M.D. The request for X Area in the X was denied. The diagnosis was pain in the X. Rationale: *"Per state guidelines, TPI is not recommended in the absence of X. In this case, the patient had X treatment around his instrumentation and X was much improved from previous after the X. The latest medicals dated X, X was getting pain in his X area in the X regions. X noted X got excellent relief of pain, improved function and decreased medications from his previous X over a year ago. However, a comparative evaluation report with objective measures of functional gains from prior injection was not fully established at this point to support the repeat procedure treatment. Submitted medicals were limited to validate reduced medication use obtained for six weeks after the injection. Clarification is needed regarding the request and on how it might affect the patient's clinical outcomes. Exceptional factors were not present."*

On X, the patient was seen by Dr. X with moderate-to-severe X XX pain. The X over a year ago offered X a solitary significant benefit and pain relief, improved function and decreased use of the healthcare system. X was able to X throughout the course of the day with less difficulty. Dr. X was trying to keep switch the patient from X as X was making X drowsy. The X was lowered to X TID. Also, an X pain medicine was prescribed. Continuation of stretching and exercise therapy was encouraged. The plan was to resubmit the request for X.

On X, a Utilization Review Referral was requested by Dr. X.

On X, a Notification of Reconsideration Adverse Determination was documented based on the review by X , M.D. The denial for TPI was upheld. Rationale: "*Per peer-reviewed guidelines, repeat X are not indicated unless a greater than X percent pain relief with reduced medication use is obtained for six weeks after an injection and there is documented evidence of functional improvement. There should be evidence of continued ongoing conservative treatment including home exercise and stretching. In this case, per an appeal letter dated X, the X provided "solitary significant benefit and pain relief, improved function and decrease use of the healthcare system". The requesting physician continues to provide no objective evidence of the results of the prior injections and relies on subjective statements to support the efficacy of the prior X. Therefore, the request for X is not medically necessary and is non-certified. The original denial is X*."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS,

FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
XX.

The previous denials have stated that there is no documentation of >X improvement over 6 weeks, and no objective functional improvement. The patient has had previous X, XX. X was noted to have excellent relief of pain, improved function and decreased medications from the X over a year ago. The improvement from the injection was described as excellent. The definition of Excellent: Of the highest or finest quality; exceptionally good for its kind; of high or superior quality or performance; Being so to an extreme degree. In my opinion, the word excellent to describe improvement, according to the definition, implies a greater improvement than X. It is documented that the patient continued with HEP and work (with increased work activity of around 60 to 80 hours). Working 60-80 hours is objective functional improvement.

The patient meets the above listed ODG criteria for X therapy. Thus, the request for X mid X area in the X is certified.

X Medically Necessary

☐ Not Medically Necessary

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES