Applied Resolutions LLC

Notice of Independent Review Decision

Case Number: Date of Notice: 6/24/2019 12:11:45 PM CST

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records –X
- Peer Clinical Review Reports –X
- Utilization Reviews –X

PATIENT CLINICAL HISTORY [SUMMARY]: X. X X is a X-year-old X with date of injury X. The biomechanics of the injury were unavailable in the given medical records. On X, X. X was seen by X X, DO for X pain which was worse than ever. X had got excellent relief following a single diagnostic X for chronic X pain associated with X. X X was hot at the time. X wanted to continue with X X as it had helped to provide diagnostic information and X. X X had failed surgical X care. On examination, X X was quite warm to touch at the time. X had decreased range of motion and moderate pain with passive range of motion consistent with complex regional pain syndrome. Treatment to date included medications (x), X surgery, X, and X. In an Adverse Determination dated X, X, DO denied the request for X x 2 (one to be done every other week) with X performed under X (due to XX will need anesthesia). Rationale: "With regard to the X X 2 with X performed under X, there was documentation of the injured worker having history of a X and reportedly had more than X improvement for over 2 weeks of X X and X pain following a single X and was consistent with a X complex regional pain syndrome associated with X/ X changes, X and X options and the plan to do a second and third X for further relief and improved function. However, there was also documentation that the injured worker was getting good relief with X pain medications including X and was also taking X and to continue active X and X and this appears to be a discrepancy of information since good relief is being achieved

with the medications and therapy and this would not support the need for additional X treatment based on the guideline criteria and therefore this request is non-certified." Per a request for reconsideration (appeal) of an Adverse utilization review determination dated X, X, MD upheld the denial with the following rationale. "The available documentation indicates that the injured worker sustained an injury to the X and is status post X with continued X pain. The injured worker underwent a X with reported X improvement for 2 weeks of relief. Additionally, it was noted that the injured worker is also having good relief with X pain medications including X. The notes on X especially noted that the injured worker is having good relief with medication management and no longer taking X. Additionally, there is no evidence of ongoing X. The examination on X demonstrated X warm to touch, decreased ROM, and pain consistent with chronic regional pain syndrome. Furthermore, the notes on X demonstrated limited ROM, X to soft touch. The provider has not provided any conclusive evidence of response to the previous injection, nor objective changes related to the diagnosis of chronic regional pain syndrome. The examination is limited on both dates and does not provide any compelling evidence of chronic regional pain syndrome or functional limitations related to the X. ODG recommends X for limited, select cases. Furthermore, there should be evidence that X therapy is incorporated with the duration of symptom relief of the X during the X phase. The provider has not provided any evidence that would support the necessity of this request. Therefore, based on the lack of submitted documentation and guideline support I recommend non-certifying this request."

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

Based on the clinical information provided, the request for X x 2 (one to be done every other week) with X performed under X (due to XX will need X) is not recommended as medically necessary, and the previous denials are X. There is insufficient information to support a change in determination, and the previous

non-certification is X. Current evidence based guidelines note that in the X phase repeat X should only be undertaken if there is evidence of increased range of motion, pain and medication use reduction, and increased tolerance of activity and touch (decreased X) is documented to permit participation in X/ X therapy. X are not a stand-alone treatment. There should be evidence that X or X therapy is incorporated with the duration of symptom relief of the block during the X phase. The submitted clinical records fail to document objective measures of improvement following prior X.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the decision is X.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

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☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL