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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Cover sheet and working documents
Notice to utilization review agent of assignment to independent review organization X
Request for a review by an independent review organization X
Utilization review determination X
Peer review X
Reconsideration/appeal of adverse determination X
Physician review recommendation X
MRI X
Reconsideration - surgery request X
MRI X
Clinical note X
Follow up note X
Office visit note dated X
Office visit note dated X
Clinical note X
Modified X
Clinical note X
Dr. X action sheet X
Order form X
Psychological evaluation X

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X year old X whose date of injury is X. The mechanism of injury occurred when X X and X. The referenced diagnosis was X X. Magnetic resonance imaging (MRI) of the X X on X revealed X changes at X with nonspecific enhancement in the X surrounding the surgical site. A note dated X is a follow-up for X pain. Pain is rated at X. Medications include X, X, X, X, X, and X. The patient complains of X pain radiating to the X. There is a history of a X which was X and resolved symptoms, however they have occurred. Pain radiates to the X level in X X. A physical examination reveals a positive X test. There was tenderness over the X X X and positive X loading. There was decreased strength of the X X and X X

rated at 4/5. Reflexes X MRI of the X X dated X reveals evidence of a X at X. There were plans for a X and a follow-up MRI. X evaluation on X stated that X should be considered a suitable candidate for the use of the X. MRI of the X X dated X revealed unremarkable postoperative findings at X, X and X or significant X. Office visit note dated X indicates that patient presents for X pain. Current medications include X. On physical examination there is X over X X. There is positive X loading. X is positive on the X. Motor strength is X except X X great XX. Reflexes are X throughout except X/X. The initial request for X trial was non-certified noting that the Official Disability Guidelines, low X chapter, only supports a X trial for individuals who have both X and X of X care and concurrent screening by X to determine their suitability for this device. This patient has continued X pain after previous X X surgery and there are complaints of X. However, there has been no X screening performed prior to this trial. Considering the absence of this required screening by X, this request is not supported. The denial was X on appeal noting that X does not meet the indications for a trial of an X since there has been no recent imaging of the X X confirming the diagnosis of X X surgery syndrome with no alternative treatments. The ODG states that X is a reasonably effective therapy for many patients suffering from X pain for which there is no alternative therapy. Without recent imaging, it cannot be confirmed that X is suffering from X pain for which there is no X. As the provider has noted, it is possible that there may be underlying X which might respond to X that was not visualized on the MRI of X. If imaging is available and reveals no X for the symptoms, then an outpatient trial of X may be considered medically indicated. Since the submitted medical records contain insufficient documentation to confirm the diagnosis of X X surgery syndrome, the request for an outpatient trial of X is recommended non-certified.

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 outpatient surgery: XX XX XX trial is recommended as medically necessary, and the previous denials are overturned. The patient presents with X X surgery syndrome with continued pain despite extensive treatment. The patient has undergone recent imaging of the X X. The patient has received XX clearance for the procedure as required by the Official Disability Guidelines. The issues raised by the initial denials have been addressed. Therefore, medical necessity is established in accordance with current evidence based guidelines.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES