Vanguard MedReview, Inc.
101 Ranch Hand Lane
Aledo, TX 76008
P 817-751-1632
F 817-632-2619

March 9, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX pain XX XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This case was reviewed by a Board Certified Doctor of Anesthesiology with experience in Pain Management with over 12 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

XX: Office Evaluation by XX. **HPI:** Pain is shooting, aching, burning, catching, constant, cramping. Low-2/10 high-9/10. ADL decreased. Relieving factors: Lying prone, hot packs, using meds. Currently, meds are working. Patient reports 70% improvement since XX facet XX/RFTC. **Assessment/Plan:** 1. Chronic pain. 2. XX. 3. XX. 4. Long term use of XX analgesic. XX meds renewed. Follow up in XX months.

XX: Office Evaluation by XX. Pre-cert XX facet XX/RFTC XX-XX, XX-XX, XX side XX, XX side XXX. Post procedure-continue meds.

XX: Procedure Note by XX. **Procedure:** XX facet XX of XX XX-XX and XX-XX.

XX: Procedure Note by XX. **Procedure:** XX facet XX of XX XX-XX and XX-XX

XX: Office Evaluation by XX. **HPI:** 80% improvement for a duration of XX days. **Plan:** Pre cert X XX trial XX pain XX

XX: Procedure Note by XX XX, XX. **Procedure:** XX XX XX and tunneling of the XX with injection of the XX, for XX XX trial.

XX: Procedure Note by XX XX, XX. **Procedure:** XX XX injection of XX.

XX: Procedure Note by XX XX, XX. XX XX injection of XX and removal of indwelling XX XX XX.

XX: Office Evaluation by XX XX XX. **HPI:** Patient reported great relief from her trial. XX estimates approximately 85-90% relief. XX states XX has not had a drop in pain like that in years. **Plan:** Pre-cert XX XX/XX permanent implant.

XX: UR performed by XX, XX. **Rationale for Denial:** The provider is requesting an XX XX XX. Documentation does not substantiate an independent XX evaluation has been obtained and evaluation states that the pain is not primarily XX in origin, the patient has realistic expectations and that benefit would occur with XX despite any XX XX. As such, this request is not medically necessary. Therefore, the request for XX pain XX is not medically necessary.

XX: UR performed by XX, XX. **Rationale for Denial:** The ODG has specific criteria for recommendation of XX XX delivery systems all of which have not been met as determined upon review of the medical record. Primarily there is no indication of the medical record of the duration of the claimant's pain or of the XX treatment methods have been tried and have not failed to relieve pain. Therefore, the request for XX pain XX XX is not medically necessary.

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

Based on records submitted and peer-reviewed guidelines, this request is non-certified. Per ODG, specific criteria for recommendation of XX XX delivery systems have not been met. There is no indication of the duration of the claimant's pain or of the XX treatment methods have been tried and have not failed to relieve pain. Therefore, the request for XX pain XX XX is not medically necessary.

Per ODG: 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)**