Applied Independent Review

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Applied Independent Review

Notice of Independent Review Decision

Case Number: **XX** ***Date of Notice:*** 03/05/2019

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Physical Medicine And Rehabilitation
Pain Medicine

Description of the service or services in dispute:

XX XX XX XX from XX XX and injection of XX into the XX XX tendon and XX XX tendon and XX XX tendon

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)

Patient Clinical History (Summary)

XX. XX XX is a XX-year-old, XX-hand-dominant XX who was diagnosed with chronic pain in both XX and incomplete XX XX tear XX. An evaluation was performed by XX on XX for complaints in the XX XX. XX. XX was status post XX XX joint XX XX XX XX procedures on XX. XX stated that the injection provided complete relief of the burning sensation in XX XX XX. It was becoming easier to do normal day-to-day activities. XX had not yet gone to an upper XX routine. At the time, XX stated the symptoms were mild to moderate. The symptoms were aggravated by reaching XX, pulling, pushing, and lifting. The symptoms were relieved by rest. The assessment was incomplete XX XX XX tear, incomplete XX XX XX tear, and chronic pain of both XX. The plan was to continue to hold on XX XX lifting routine, continue to avoid all nonsteroidal anti-inflammatory drugs (NSAIDs) for another XX weeks, and continue activity as tolerated and home exercise program daily. Per a telephone call dated XX, XX. XX called XX and stated that overall XX XX were still maintaining and doing well from the previous XX XX treatments; however, XX had noticed that with needing to XX XX XX for an extended period, XX symptoms worsened. XX would like to have repeat XX XX XX procedures. An order was submitted for the procedure.

Treatment to date consisted of medications (XX, XX XX, XX XX XX, XX injection, and XX), XX XX injections on XX, XX therapy, and home exercise program.

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In a letter dated XX, XX indicated XX. XX had recently discussed undergoing repeat XX XX XX XX XX concentrate procedures. They did receive a denial letter on XX behalf. The letter stated that the denial was given due to XX. XX only having mild improvement from XX procedure at XX follow-up visit on XX. XX clarified that it was not uncommon for XX to only have mild improvement at the time. XX. XX noted that XX had overall 75% improvement; however, these effects were beginning to diminish. XX noted that with increased activity (i.e., pushing XX XX, using XX) that XX pain was increasingly more intense. The pain benefit began to regress approximately XX to XX weeks prior. XX discussed that repeating the XX XX XX XX XX concentrate procedures would provide XX. XX additional pain benefit; ideally, preventing the regression of XX symptoms further.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The provided records noted a history of XX pain that had not improved with medications or injections as well as therapy. However, the use of XX XX XX or XX XX as a therapy for XX pain is not recommended by current evidence based guidelines as there is very limited evidence in the literature that the therapy is effective as compared to standard treatment. Most research is poor quality with high bias. This treatment would be considered investigational in nature. There were no exceptional factors noted in this case to support proceeding with the requested treatment over other standard treatment options for the claimant's symptoms and physical exam findings. Therefore, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld. Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic XX
- ☐ 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 and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)

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☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

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