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IRO REVIEWER REPORT

Date: 5/6/2019 5:34:23 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX to an XX as an outpatient procedure with fluoroscopy performed under anesthesia

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

REVIEW OUTCOME:

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

☐ Overturned	Disagree
☒ Partially Overtuned	Agree in part/Disagree in part
☐ Upheld	Agree

The request is partially overturned. A XX replacement with the XX XX is medially necessary. An XX replacement with XX is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX-year-old XX who was injured on XX. At the XX of XX XX, XX XX XX XX, XX XX XX the XX causing both XX to XX and develop severe pain. XX was diagnosed with pain in unspecified XX (XX.XX), XX affecting regions of the XX and XX, XX and XX region (XX.XX), and complex regional pain syndrome I of other specified site (XX.XX). XX. XX was evaluated by XX XX, XX on XX and XX. On XX, XX reported moderate XX and XX XX pain. XX had mild XX tenderness. The XX (XX-D) score was 30/60, which showed moderate reactive XX and XX. XX generalized XX disorder (GAD)-7 score was 2/21. On XX, XX. XX presented with the assistance of the XX representative, which enjoyed for well over XX years. Due to the increased output, XX XX was at the end of life at the time. XX XX and XX pain had escalated dramatically. XX was requesting further XX for XX XX XX pain associated with swelling, sensitivity and burning pain effectively treated with XX XX. XX. XX recommended immediate replacement of XX XX as an outpatient. This would be a XX swap to XX, which was a much more XX XX system. This would give much longer XX life

and greater XX XX. The treatment to date included medications (XX, XX, XX, XX, and XX) XX, XX XX XX XX (XX) reconstruction on XX, medial XX, lateral XX XX release, XX rich XX, durable medical equipment, XX XX XX, restrictions, and XX from XX to XX. Per a Physician Advisor report dated XX, the request for XX XX to an XX as an outpatient procedure with fluoroscopy performed under anesthesia was denied by XX XX, XX. Rationale: A peer to peer review discussion was unsuccessful despite calls to the doctor's office. "Official Disability Guidelines (ODG)-TWC provides indications for XX XX including complex regional pain syndrome (CRPS) and failed XX surgery syndrome (FBSS). As XX for both XX and XX-XX XX are nearing the end of life, there are both early XX XX and end of service notifications. Typical life maybe XX to XX years for XX XX, but this depends on the XX. In this case, the claimant has a chronic history of XX XX and XX XX XX pain. The claimant is status post XX XX XX replacement on XX. The claimant currently notes the end of life on the XX, which the claimant had enjoyed for well over XX years. The claimant reports XX and XX pain has escalated dramatically. XX replacement is indicated to address the claimant's pain complaints, given the good results with XX XX XX (XX) use for over XX years. Fluoroscopy use for replacement during the procedure and anesthesia are indicated for the performance of XX XX. However, the guidelines XX not support a specific XX / provider for the XX XX. Therefore, partial certification is recommended for XX XX XX as an outpatient procedure with fluoroscopy performed under anesthesia. As the provider has not been available to discuss a modified treatment plan absent the XX name and guidelines XX not specify XX names, the request in total cannot be authorized. Recommend non-certification for XX XX to an XX as an outpatient procedure with fluoroscopy performed under anesthesia." Per a Utilization Review decision letter dated XX, the prior denial was upheld by XX XX, XX. Rationale: Peer to peer discussion has not been achieved despite calls to the doctor's office. Regarding the XX XX, the patient was previously treated with a XX XX XX. The primary XX XX had expired. There were reports of XX and XX pain, which had increased. This case was previously denied due to no indication for the specific XX / provider for the XX XX XX XX. Although a XX replacement may be warranted, there was no indication the patient required the XX XX rather than a replacement of the XX XX. As such, the request for XX replacement to an XX as on outpatient procedure with fluoroscopy performed under anesthesia is non-certified. Regarding XX-hour stay, the request has been recommended as an associated service to be used in conjunction with the requested XX XX XX (XX) XX replacement. However, the request for replacement was deemed not appropriate at this time. Therefore, the requested service is also not supported. As such the request for XX-hour stay for XX is non-certified."

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

The claimant has been followed for a history of chronic pain for which a XX XX XX was XX. The records through XX indicate that the XX for the currently implanted XX XX XX was at end-of-life and a XX XX was being recommended. The XX system was recommended as this was a more powerful system. However, the records provided for review did not provide a specific rationale for the use of the XX system over a XX XX change for the XX system.
Therefore, this reviewer would recommend partial approval for a same XX XX of the currently XX XX XX XX system.

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 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 & 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

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL