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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

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

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)

Provide a description of the review outcome that clearly states

whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a x who was injured on X. X reported that X. X stepped in to separate them. X stated X practiced the restraint method that was taught to X in training. X reported that one of X"knocked" X around. X attempted to pull X. X felt a pop in X right shoulder followed by pain. The diagnosis was superior glenoid labrum lesion of right shoulder, subsequent encounter (X). X was seen by X, FNP / X, MD on X for right shoulder pain. X presented with a history of right shoulder pain for X years. X did previously undergo X. X was in the process of being evaluated and approved for a X. It was ultimately determined that X had a X. X most significant pain was from the cervical spine to about the elbow focusing on the shoulder but did have pain that could run further along. Pain was exacerbated with the range of motion of the shoulder or the upper extremity, X noted especially when typing on a keyboard such as required with X job significant increase in pain. Medication regimen did help with the symptoms. At the time, the pain was rated at X. It was rated at X with the medications, and X without the medications. On examination of the right shoulder, there were no deformities, muscle atrophy, swelling, or redness. Well-healed surgical scars were noted. There was tenderness to palpation over the anterior and posterior aspect. Range of motion was decreased with flexion, abduction, and external rotation. Empty can maneuver, Neer's test, and cross-arm tests were X. There was a decrease in sensation along the medial aspect of the right extremity to touch. A urine drug test dated X was X. The assessment included pain in right shoulder; injury of right

ulnar nerve, unspecified injury location; chronic pain syndrome; nerve pain; and muscle spasm. A X had been ordered. X was to finish a mental health evaluation and obtain full approval to move forward. X attended a psychological evaluation by X, X on X to determine if X would be a psychologically appropriate candidate for a X. The diagnoses were mononeuropathy, unspecified, and injury of the right ulnar nerve, unspecified injury location. Upon evaluation, X was capable of handling the psychological and physical discomfort that accompanied various medical procedures. X-rays of the right shoulder dated X showed findings that may be seen with X. An MRI of the cervical spine dated X showed X. At X contributing to narrowing the central canal to X. The central canal narrowed to X millimeters (mm)X. Treatment to date included X. Per a letter of medical necessity / prior authorization request dated X and X; X, MD documented that X was medically necessary for functional improvement and pain management related to chronic pain syndrome. For X years, X had suffered from chronic pain symptoms of the right shoulder. X reported pain level of X on average. X reported the worst pain in the previous month, which was X. X had attempted to alleviate pain with X. Imaging studies were obtained to exclude surgically treatable nerve entrapment pathology. X had also failed or had not sustained long-term benefits from the following pharmacological therapies: X medication. The pain limited normal activities within their daily living; ability to work; ability to fulfill family role; and ability to fulfill social role. X demonstrated more than X pain relief responses to a X. Due to ongoing and pervasive chronicity of pain and activity limitation, and in discussion with X, they have decided to proceed with a X. A X. X had completed a psychiatric evaluation by a qualified health professional and deemed appropriate for X. Furthermore, it was documented that “X. The systematic review for safety and effectiveness of X concluded that collectively the evidence reveals significant improvement in patients suffering from chronic pain when utilizing X. Based on the patient’s medical history and current condition, and considering the failure of

conservative standards of care, it is my professional opinion that a X is the most appropriate and medically necessary next step in the patient's treatment plan for their chronic pain. Per a utilization review adverse determination letter dated X and peer review dated; the request for X was denied by X MD. Rationale: The Official Disability Guidelines (ODG) by X "Not recommended, including X. According to the documentation provided for review, X has chronic right shoulder pain. X has been treated with X. The record indicates that pain and functional limitations persist despite previous conservative treatment. The plan includes a X. However, guidelines do not support the use of this treatment for chronic pain. There is no documentation of exceptional factors and / or literature superior to that provided by guidelines with which to support this treatment as an outlier to the negative guideline reference. Therefore, the request for X is not medically necessary. Dr. X wrote an appeal letter on X regarding denial of X. Dr. X commented that "X. The therapy is a minimally invasive, non-pharmacologic treatment option for the management of chronic pain. In my clinical judgment, X is the best option for my patient. Please approve X for X who lives with chronic, debilitating pain every day. "Per a reconsideration review adverse determination letter dated X and peer review dated X, the prior denial was upheld by X MD: Rationale: "According to guidelines X is not recommend- including several terms and device variations, including X. Given this is not recommended. Therefore, the request for appeal - X is Upheld. "Per an appeal letter dated X, Dr. X had been appealing the denial of authorization for X. Due to ongoing and pervasive chronicity of pain and limitation, Dr. X requested approval of a X. A X would determine success of the treatment and confirm whether it was in fact medically necessary to alleviate chronic pain before permanent implantation. X offered chronic pain patients a non-opioid solution to their chronic and debilitating pain when the pain was not responding to other treatments and significantly interfered with their psychosocial wellbeing, ability to function and participate in activities of daily living

and overall quality of life. Furthermore, it was documented that “X. The therapy is a minimally invasive, non-pharmacologic treatment option for the management of chronic pain. In my clinical judgment, X is the best option for my patient. Please approve X. “Thoroughly reviewed provided records including clinical notes and peer reviews. Patient with intractable pain issues despite conservative treatment, for which intervention such as X may be warranted. The provider has laid out significant criteria for which extenuating circumstances have been documented to warrant request For X. X is medically necessary and certified.

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

Thoroughly reviewed provided records including clinical notes and peer reviews. Patient with intractable pain issues despite conservative treatment, for which intervention such as X may be warranted. The provider has laid out significant criteria for which extenuating circumstances have been documented to warrant request For X is medically necessary and certified.
Overturned

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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**