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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 Overturned (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 who was injured at work on X. X stated that during the normal course and scope of X employment with X. When X regained consciousness, X was still on the floor. The diagnoses were fracture of orbital floor, left side, initial encounter for closed fracture; zygomatic fracture, unspecified side, initial encounter for closed fracture; and post-concussional syndrome. On X, X was seen by X, DO, for a follow-up of X ongoing complaints. X reported that these symptoms were present after involvement in a work-related injury on X. X stated that while working during the normal course and scope of X employment with X. When X regained consciousness, X was still on the floor. X was evaluated at X where X underwent x-rays, CT scan, and was informed X had a fracture of the face. X was then evaluated by Dr. X, a plastic surgeon, underwent surgery for X facial fracture. X was also evaluated by a neurologist and underwent CTs, MRI. X was then evaluated by Dr. X, underwent another surgery for X face with a graft. X was then evaluated at X. X was also evaluated by an ophthalmologist and was X. X was evaluated by a Designated Doctor and was provided X impairment rating. Decision and order stated that X had reached maximum medical improvement on X with X Impairment rating. X reported of ongoing facial pain and headaches. X reported blurred vision of X left eye with pain. X stated X forgot things, did not like doing stuff, could not organize, could not calculate like how X used to. X stated X forgot and had trouble with X train of thoughts. X reported no flashbacks, nightmares at the time. Due to the nature and severity of X symptoms, X presented to the office for evaluation and management of X condition. X was examined and recommended evaluation with the neurologist and ophthalmologist. On X, Dr. X, the neurologist, requested X. X was re-evaluated by Dr. X in "X." Per X, the evaluation with Ophthalmologist was denied by the carrier. X was seen with a history of head injury. X stated X had trouble in eating due to facial pain on the left side and blurred vision of left eye. X reported increase in facial pain and trouble in sleeping. X reported intermittent swelling of face. X stated X felt depressed. X reported headaches X times a week, could not organize, could not calculate like how X used to and had trouble with X train of thoughts. X stated cold weather and gush wind on X face would increase X

pain. X reported no changes in medical history since the prior visit. X stated the treatment helped but X continued to report burning pain in X face, which flares X times in a day. X also reported that X pain was aggravated by light touch and had increased due to concerns with X scar tissue. On the day, X reported symptoms were persistent. At the time, X rated pain X on the left side of X face, which was decreased compared to X prior visit, attributed to the addition of X, pain went down to X. X was taking medications as needed and using the X. X had not started X due to a lack of approval from Workers' Compensation; no update from X lawyer either was reported. X continued to perform X home exercise program (HEP) daily, but it provided minimal pain relief. At the time, X was searching for a surgeon in X. X started taking X with Dr. X, but it was making X stomach sick. X would talk with Dr. X to discontinue this. X reported constant facial pain described as electrical shock-like and burning, associated with hypersensitivity. Chewing, wind, and light touch exacerbated the pain. X was doing a home desensitization program. Medications, including X. Physical examination revealed X was in no X. Eyes showed extraocular movements (EOM) were intact. Examination of the face revealed tenderness of the left eye down to the left side of the upper lip (X distribution). X was noted on the left side, as well. Extremities showed X. Cranial Nerves II-XII appeared grossly intact. The TIRR - Desensitization Therapy for X left facial pain was not approved. They tried X times to contact them with no response; would discuss this with X lawyer. PMP was checked and noted to be compliant. X was refilled. X was advised to continue X. X was started. Urine drug testing results were reviewed on the day and was noted to be X. In an undated letter, Dr. X stated, "I am prescribing the X. X has shown efficacy in managing fractures by providing pain relief and improving functional outcomes. In-home therapeutic regime will consist of X. Interferential current is recommended to supplement existing treatments, modalities and optimize patient comfort while adhering to evidence-based guidelines. "Treatment to date included. Per a utilization review adverse determination letter dated X and a peer review report dated X by X, DO, the request for X was denied. Rationale: "In this case the request is experimental and investigational for the treatment area. Given that, the request is denied. Therefore, X is not medically necessary. "On X, X wrote a letter regarding preauthorization request for reconsideration (appeal) for denial request of X. It was stated that the medical provider, Dr. X, had requested this medical treatment because there was an ongoing condition that required treatment. The attached medical records supported the efficacy of the treatment;

and established the clinical indication and necessity of this treatment. Per a reconsideration review adverse determination letter dated X and a peer review report dated X by X, MD, the request for X was denied. Rationale: "Regarding X of the left maxillary/left orbital for X days. ODG by MCG notes, 'X, "Not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm." "X is NOT recommended for any of the following: Knee osteoarthritis (X. ODG by MCG notes X is "Not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm. X is NOT recommended for any of the following: X." Within the documentation provided for review, the claimant has facial pain due to facial fractures. The claimant reports burning pain in the face. However, the provided documentation does not support the use of this X. Exceptional factors to the guideline recommendations have not been made. Thus, the request is not medically necessary and is denied. Therefore, the request for X is not medically necessary. Thoroughly reviewed provided records including provider notes and peer reviews. Patient with continued pain issues involving left face but unclear if would benefit from X. While the patient has tried a number of different modalities for their pain, use of X. Request is not warranted and may consider other options for neuropathic pain or fracture-related pain. X is not medically necessary and non-certified.

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

Thoroughly reviewed provided records including provider notes and peer reviews. Patient with continued pain issues involving left face but unclear if would benefit from X. While the patient has tried a number of different modalities for their pain, use of X. Request is not warranted and may consider other options for neuropathic pain or fracture-related pain. X is not medically necessary and non-certified.

Upheld

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)