

## Notice of Independent Review Decision

**X:**

**IRO Case number:** X

### Description of the services in dispute

X

### Description of the qualifications for each physician or 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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

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

The claimant is a X diagnosed with trigeminal neuralgia (supraorbital). This review is to determine the medical necessity of X.

The Letter of Medical Necessity by X dated X stated that the claimant suffered a work-related injury on X. Subsequently, the claimant developed supraorbital neuralgia causing debilitating pain. The document further stated that, "The rationale behind this procedure is based on the fact that X has been suffering from pain and tenderness from the injury X sustained. X cannot do some activities of daily living due to the excruciating nature of X pain. X cannot function in every day life due to the limitations X pain forces on X. The conservative treatments have not provided sufficient relief. X has tried multiple medications without any benefit. Based on my clinical judgment, the X offers a higher success rate and is less likely to result in further complications compared to nerve transection, which would involve a more invasive procedure with greater risk of nerve damage and complications."

The X dated X revealed, "IMPRESSION: 1. X. 2. X." X disease was described as, "X: Complete opacification of the right maxillary sinus. Moderate opacification of the remainder of the paranasal sinuses. The mastoid air cells appear clear." There was no bone fracture or brain injury noted. The claimant had a history of headache and dizziness after X work-related injury.

The Follow Up Visit by Dr. X, MD dated X stated that up to X. The doctor stated that X would X. X will also have the claimant attempt X.

The Neurosurgery Consult Note by Dr. X, MD dated X stated that, "Since then X has had exquisite tenderness over the region of the scar, with tapping producing radiating pain in the X. X reports mild sensory changes in the same distribution. The pain is constant, and worsened with palpation. Mild improvement with X. It significantly impairs X quality of life and function."

Finally, the Denial Letter by X dated X stated that, "On behalf of X, we decided that the services or treatments described above/below are not medically necessary or appropriate. This means that we do not approve these services or treatment."

### **Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision**

The claimant is a X with a work-related injury and X. The claimant has had a significant affect to X quality of life and X is currently being recommended X. There are limited options for patients with this type of injury and X. This is considered standard of care and is medically necessary for this claimant's condition as noted in the literature as listed below. There are no other options that are nonsurgical that provide similar levels of relief and, therefore, in this setting the surgery that was recommended is within the standard of care and is medically necessary.

The X study revealed that X.

The surgical approach allowed to obtain good therapeutic results with a low rate of complications, as stated in Frontal Site Surgery For Chronic Migraine Therapy (2023).

X is a rare disorder clinically characterized by the following triad: 1) forehead pain in the territory supplied by the supraorbital nerve, without side shift; 2) tenderness on either the supraorbital notch or trajet of the nerve; and 3) absolute, but transitory relief of symptoms upon supraorbital nerve blockade. The pain presents with a chronic or intermittent pattern. In addition, there may be signs and symptoms of sensory dysfunction (hypoesthesia, paresthesia and allodynia), and typical "neuralgic features" (lightning pain and exteroceptive precipitating mechanisms). However, sensitive and neuralgic features are not constantly present and seem to be

more frequent in the secondary, usually post-traumatic, forms. (Supraorbital neuralgia, 2006)

The Trigeminal Neuralgia Involving Supraorbital and Infraorbital Nerves (2010) study stated that the persistence of protracted unilateral forehead/ocular pain, tenderness over the nerve and repeated blockade effect strongly suggest the diagnosis. Surgical treatment can be used when the medical treatment fails or in patients who do not tolerate the pharmacological treatment.

The Supratrochlear Neuralgia (2017) study stated that supratrochlear neuralgia is an uncommon disorder causing pain in the medial region of the forehead. It may be differentiated from supraorbital neuralgia and other similar headaches. Neuralgias are based on the topography of the pain and the response to anesthetic blockade.

Therefore, it is the professional opinion of the medical reviewer to overturn the decision to deny X due to medical necessity. This means that the claimant will receive coverage for the requested service.

### **Description and source of the screening criteria or other clinical basis used to make the decision**

- ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase
- AHRQ - Agency for Healthcare Research and 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
- ODG - Official Disability Guidelines & Treatment 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)