

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/01/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Methadone 10 mg every day, Take 1/2 tab in morning and 1/2 tab at night (quantity of prescription not indicated)

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

Board Certified PM&R
Board Certified Pain Medicine

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 health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Request for reconsideration by the patient dated 08/23/13
Undated letter of medical necessity
Prior reviews dated 08/15/13 & 09/05/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. No specific mechanism of injury was noted. There was no clinical data available for review. No prior patient history, clinical evaluations, physical examinations, or any diagnostic testing was submitted for review. Per the letter that was undated, the patient was stated to have benefits from Methadone over Hydrocodone. The patient did try to revert back to Hydrocodone per a required medical exam recommendation; however, this was reported not to be successful.

The request for Methadone was denied by utilization review on 08/15/13 as there was insufficient documentation to support its use.

The request was again denied by utilization review on 09/05/13 due to limited documentation.

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

This patient has been followed for what appears to be ongoing chronic pain since the date of injury in xxxx. It appears the patient is utilizing Methadone at this point in time. Other than a letter indicating that a change back to Hydrocodone per a RME recommendation failed, there is no clinical history for this patient. No prior clinical evaluations were available for review to establish the efficacy of ongoing Methadone use. There is also no documentation regarding recommended compliance testing or evidence of functional improvement with Methadone that would require its ongoing use. It is incumbent on the requested physician to provide appropriate documentation to support the ongoing use of a controlled substance such as Methadone. As this has not been provided for review, it is this reviewer's opinion that medical necessity has not been established. As such, the prior denials are upheld at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE

AHCPR-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 JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)