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08/13/18

Description of the service or services in dispute:

NDC – XXXX: XXXX

Description of the qualifications for each physician or other health care provider who reviewed the decision: Board Certified PM&R

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

☐ Overturned (Disagree)

☑ Upheld (Agree)

☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)
XXXX is a XXXX who was diagnosed with intervertebral disc displacement of the lumbar region (M51.26), postlaminectomy syndrome (M96.1), and radiculopathy of the lumbar region (M54.16). XXXX sustained a low back injury on XXXX. XXXX underwent laminectomy and fusion of the lumbar spine (undated).

The treatment to date included medications (XXXX) and surgical intervention. The medications were working adequately to facilitate activities of daily living and controlled pain levels which ranged as low as 3-4/10 with medications and as high as 7-8/10 without medications.

Per a peer review by XXXX, and a utilization review decision letter dated XXXX, the request for XXXX was denied as it did not meet established standards of medical necessity. Rationale: "XXXX is not medically necessary because even though there is a urine drug screen (UDS) to verify compliance with this medication and that the medication is helping the claimant; there is no indication that non-opiate pain medications cannot be added in order to reduce the reliance on opiates in general. The ongoing use of opiates due to an old injury and for non-malignant pain is not recommended. Therefore, XXXX is not medically necessary. However, if the claimant is taking this drug, weaning would be recommended".

An appeal letter was written by XXXX on XXXX, documenting the medical necessity of XXXX. XXXX stated in an office visit dated XXXX, that a previous physician prescribed XXXX, which was later discontinued due to side effects of severe nausea, vomiting, and

tachycardia. XXXX was placed on XXXX on XXXX; however, this was discontinued on XXXX due to side effects including dizziness and elevated blood pressure. A peer-to-peer review was completed on XXXX by XXXX. At that time, XXXX stated XXXX was not medically necessary; however, a later peer review was completed by XXXX on XXXX, determining XXXX was medically necessary. XXXX stated that XXXX had been tried on numerous medications including nonsteroidal anti-inflammatory medications over the prior few years, but nothing gave XXXX the relief such as XXXX. XXXX also indicated to XXXX that XXXX urine drug screen had also been consistent. A required medical examination was completed by XXXX, in which XXXX documented that XXXX had been tried on various medications including nonsteroidal anti-inflammatory drugs, which failed to afford XXXX significant relief. XXXX provided pain relief, allowing XXXX to be active in the home environment and perform his exercises. There was no documented evidence of aberrant drug behavior or intolerable side effects and urine drug screens had been consistent. Given these facts, the continued use of XXXX was necessary and met the Official Disability Guidelines criteria for opioid treatment. XXXX documented that the continuation of XXXX had been reviewed by several providers, and the continuation of XXXX had been determined medically necessary, yet XXXX continued to be denied. XXXX requested approval of the medication as it was medically necessary.

Per a peer review by XXXX, and a utilization review decision letter dated XXXX; original non-certification was upheld. XXXX denied the requested service with the following rationale: "According to a letter by XXXX on XXXX, there was no documentation of the claimant's specific subjective and objective findings and diagnoses, and rather there was documentation that XXXX were previously prescribed and were later discontinued due to side effect problems and nonsteroidal anti-inflammatory medications were tried over the past few years but reportedly nothing gave significant relief as compared to XXXX which also allowed the claimant to be active in the home environment and perform his exercises and urine drug screening was consistent. There was also documentation of the need to approve XXXX and that continuation of XXXX was previously reviewed by several providers and was determined to be medically necessary but was also continuing to be denied. However, there was no documentation detailing the claimant's specific subjective and objective findings that would be accounting for a pain condition to support the need for ongoing opioid treatment and there was no documentation of the claimant's pain coping skills ever being addressed and the long-term use of opioids for chronic pain is not supported in the guideline criteria. This request is not recommended to be certified. Therefore, XXXX is not medically necessary. Weaning is recommended."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

I agree with the prior peer review on XXXX and utilization review on XXXX. The request for XXXX is not medically necessary. I find no documentation of examination findings indicating ongoing long-term use of narcotics. Further, ODG recommends against long-term use of opioids due to poorer long-term outcomes. Request for XXXX is not certified. Given the documentation available, the requested service(s) is considered not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.