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DATE OF REVIEW: 11/27/2018 Date of Amended Decision:11/30/2018
Date of Amended Decision: 12/04/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XXXX

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

M.D. Board Certified in Physical Medicine and Rehabilitation.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient was born on XXXX and has date of injury on XXXX. The patient's treating diagnoses include XX sided XX, XX disc at XX-XX and XX-XX, XX XX, XX XX, XX XX and XX XX XX XX at XX-XX. MRI imaging of the XX XX of XXXX demonstrated a broad-based XX.XX mm XX XX XX XX causing XX of the proximal XX XX XX. On XXXX, the patient was seen in follow-up by XXXX and was noted to have multiple diagnoses as above. The patient reported that medications took the XX XX of the pain to a level of XX-XX/10. Six pages of a seven-page report are available in the medical record. The clinical impression/treatment plan is missing. A physician review of XXXX concluded that XXXX was medically necessary for treatment of XX but there was no peer to peer contact and thus the request was denied as not medically necessary. A request for XX notes that this patient has XX XX pain and for that reason the request was medically necessary but there was no peer to peer contact and therefore the request was denied. A request for XXXX was discusses. That report notes that the medial record did not document XX as a XX diagnosis. A certification of medical necessity from XXXX notes that the patient is XX from XXXX and XXXX medications were discontinued on XXXX. The patient was noted to have XX pain which affected XXXX XX XX. Therefore, the request was made for the patient's medications overall to be continued.

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

Per ODG references, the requested "XXXX" for the patient is medically necessary.
Medical necessity of XXXX QTY XX, days supply XX: Certified

This is a retrospective request back to XXXX. XXXX is recommended by the Official Disability Guidelines for treatment of XX pain. The medical records do indicate that this medication has been used successfully for treatment of XX pain from XX. Therefore, in this situation, the request is medically necessary and should be certified.

XXXX QTY XX, days supply XX: Certified, Generic Acceptable
This is a generic for XX. The Official Disability Guidelines notes that this medication is recommended for treatment of both acute and chronic pain. The medical records indicate the patient does report benefit from this medication. Therefore, in this situation the request is medically necessary and should be certified/generic acceptable.

XXXX QTY XX days supply XX" for the patient: Certified

While the Official Disability Guidelines do not discuss this medication, FDA approved labeling information recommends XXXX for treatment of XX or XX. The medical records indicate that this medication has been used for treatment of XX in this case.

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 KNOWLEDGE BASE
- ☐ 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: