CASEREVIEW
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December 2, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XXXX, XX tablet every 8 hours #90, XX days

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

This physician is a Board-Certified Anesthesiologist with over 12 years of experience including Pain Management.

REVIEW OUTCOME:

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

☒ Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a XXXX. XXXX underwent XX of XX/XX. Current diagnosis: 1. XX of XX of XX XX, 2. XX pain XX, 3. Strain of XX, XX and XX of XX XX, 4. Long term (current) use of XX XX.

On XXXX, the claimant presented to XXXX for medication refill. At the time XXXX current medications included: XXXX. Plan: The claimant was placed on a XXXX to try to XX XX XXXX current flare-up of symptoms. XXXX regular medication regimen was renewed.

On XXXX, the claimant presented to XXXX for medication refill. XXXX reported XXXX symptoms were fairly stable. Medications were renewed.

On XXXX, the claimant presented to XXXX for routine follow-up and medication refill. XXXX reported XXXX chronic XX XX pain level was a little higher. XXXX did state that the last time

it flared up, the steroid pack helped XXXX symptoms. XXXX reported the XXXX prescription was denied by XXXX because they stated it was still good for XXXX even though it expired last XXXX. XXXX reported that medication regimen continued to allow XXXX to work and perform XXXX XX. On examination XXXX had XX XX and XX. XX XX features present XX. SLR negative. Plan: Current regimen of XXXX were filled. Pertaining to the XXXX, claimant understood the risks of chronic XX use which includes XX, XX, dependence and XX induced XX XX. Claimant would monitor XX XX pain and if it becomes worse, XXXX may be put on a XXXX at next visit.

On XXXX, the claimant presented to XXXX for routine follow-up and medication refill. XXXX stated XXXX had been having XX XX pain across XXXX XX XX XX into XXXX mid XX XX. XXXX reported the pain was every day but XXXX continued to walk and had been working really hard to XX XX XX, which XXXX did. The claimant brought XXXX recent impairment rating where the evaluator recommended physical therapy and to go through a XX/XX and XX down on XXXX. The doctor had recommended XXXX XX down to XXXX versus XXXX current medication regimen. XXXX explained that this was not possible for the claimant because XXXX continued to maintain a full-time position despite XXXX current XX pain problems and really would not be able to go through XX now given XXXX new position at work. The claimant stated without the medication XXXX would be XX due to XXXX XX pain. Current medication regimen was renewed. The claimant was counseled about XXXX, XX XX goal as well.

On XXXX, through a UR process, XXXX was approved by XXXX.

On XXXX, the claimant presented to XXXX for routine follow-up and medication refill. The claimant stated because of the XX weather XXXX XX symptoms were XX XX now than previously. XXXX stated the XXXX does help with those symptoms. XXXX has now been XX to XXXX and was hoping the new responsibilities would not affect XXXX chronic XX XX pain. XXXX reported continued adequate XX benefit from the XXXX. XXXX also takes XXXX XX as needed for muscle XX. XXXX denied any XX XX XX or red flag symptoms. Plan: Medications were refilled without any changes. There was a discussion about alternative treatment options, but the claimant stated XXXX had injections in the past with no relief and is not keen on something like a XX XX XX.

On XXXX performed a UR. Rationale for Denial: Based upon the medical documentation presently available for review, the above-noted reference would not support a medical necessity for this specific request as submitted. The submitted clinical documentation does not provide any data to indicate that utilization of a XX medication definitively enhances functional capabilities. Consequently, presently, based upon the medical documentation available for review, medical necessity for this specific request as submitted is not established for the described medical situation.

On XXXX wrote a letter of appeal in which XXXX clarified XXXX was asked for the authorization of XXXX for an extended period of time (i.e., XX months) to assist XXXX staff with not having the burden to submit for authorizations monthly. XXXX reiterated that the current medication regimen allows the claimant to continue working full-time and perform

XXXX own activities of daily living. XXXX stated that without the medication, XXXX would be XX due to XXXX XX pain.

On XXXX performed a UR. Rationale for Denial: The provided records did not address the previous reviewer's concerns. While benefit with XX was reported, no specific functional improvement or pain reduction using a visual analog scale (VAS) information was provided. Further, the records did not document recent XX XX XX or any risk assessments which would be indicated as the claimant's current XX equivalent does (XX) exceeds the maximum recommended by ODG. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request.

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

Based on the records submitted and peer-reviewed guidelines this request is certified. Claimant has demonstrated benefit with XX. XX XX screening shows appropriate compliance. Claimant has returned to work which satisfies ODG criteria. Therefore, this request for XXXX, XX days is found to be medically necessary.

PER ODG:

XX

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**

☐ **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)**