Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Date notice sent to all parties: 04/23/18
IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Prescription for XX 10/325 mg

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Anesthesiology
Certified by the American Board of Anesthesiology
Certified by the American Board of Anesthesiology/Pain Management
Fellowship Trained in Pain Management

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

Prescription for XX 10/325 mg – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:
According to the medical records provided for my review, this patient was initially evaluated by XX on XXXX for complaints of right knee pain following right knee arthroscopic surgery on XXXX. At the time, the patient was started on XX and XX, as well as XX 7.5 mg three times a day. Three years later, on XXXX, XX, in a follow-up note, indicated that the patient received "best" relief from lumbar sympathetic blocks, yet recommended a spinal cord stimulator. On XXXX, a dual lead spinal cord stimulator was implanted by XX. Subsequent follow-up visits documented the patient's report of anywhere from 70% to "near 100%" relief of knee pain with continued use of postoperatively of XX to 7.5 mg twice a day. An attempt was made to decrease XX to XX, but this apparently did not provide sufficient relief, prompting XX to restart XX 7.5 mg twice a day as of XXXX. That

dose and frequency of XX continued from that point, despite XX documentation of the patient receiving at least 70-80% improvement in XX pain from the spinal cord stimulator. Each of XX subsequent progress notes indicated that the patient had continued to use XX 7.5 mg at least twice daily, yet seemed to imply that this was a reduction in XX use when, in fact, it was merely a continuation of the same dose and frequency. A request to increase XX 7.5 mg to three times daily was recently made by XX, despite XX continued reports of the patient receiving significant pain relief from the use of the spinal cord stimulator. Those requests also documented the patient's ongoing complaints of depression and anxiety. Two different physician advisors reviewed the request for XX 7.5 mg three times a day (#90 per month) and recommended non-authorization. A peer review on XXXX similarly recommended non-certification of the request for 90 XX 7.5 mg tablets on a monthly basis, to be taken three times a day, citing the fact that the patient had been taking XX 7.5 mg twice a day since the spinal cord stimulator was implanted and that there was no indication of increased pain to necessitate a more frequent dosing of the medication nor an explanation for the patient requiring the ongoing use of XX in the face of supposed significant pain relief from the spinal cord stimulator.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the documentation reviewed, this patient supposedly has obtained anywhere from a minimum of 70% to 80% up to a maximum of "near 100%" relief of XX right knee pain from the implantation of the spinal cord stimulator XX performed. However, despite this alleged pain relief, the patient has never reduced the amount of XX XX has been taking since implantation of the stimulator and now is seeking to take XX/XX even more frequently than XX had been taking it prior to the spinal cord stimulator implantation. If the spinal cord stimulator is providing the degree of relief that is alleged by XX in XX records, then there is no medical reason or necessity for the patient to continue to need XX and/or XX, much less more than XX was taking prior to the spinal cord stimulator implantation. Additionally, it appears that, at least to some extent, the XX XX/XX is being prescribed in part to treat the patient's psychological pain issues, for which XX has also recommended a behavioral pain program. Therefore, in my opinion, there is no medical reason or necessity for the patient to continue taking XX or XX at all nor for approving the request for increased dose and frequency of XX to the requested prescription amount. Therefore, the requested prescription for XX 10/325 mg is not medically necessary or appropriate and the previous adverse determinations should be upheld at this time.

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**

X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **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)**