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Houston, TX 77060
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November 6, 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:
This case was reviewed by a Board-certified XX who is considered to be an expert in their field of specialty with current hands on experience in the denied coverage

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

Upheld (Agree)

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX. XXXX was diagnosed with diagnosis XX (XX) and XX. XXXX has a history of XX XX and severe XXXX. Treatment included medications, and a XX day admission for XX XX. Progress notes dated XXXX noted the claimant had a previous XX XX with XXXX (XX), as well as XX XX as a XX with XXXX. Treatment discussed at previous visit last seen in XXXX a trial XX, the claimant was noted against taking any medication at times but was interested in doing therapy. Since visit in XXXX, the claimant ended up seeing a different doctor who lost XXXX medical license and now needed a XX XX. More recent complaints from the claimant are general XX, XX to XX and do XX. Recommendations given were talk of switching XXXX, due to XX XX with XXXX and possible complication from higher XXXX doses but didn't want to switch. The claimant reported XXXX has more XX in XXXX. The claimant was recommended to continue XXXX, but no note from XXXX as to when XXXX initially started. Some notes by XXXX indicates XXXX started in XXXX and maintained through XXXX. Inconsistency given of XXXX diagnosis or reason to continue. Visit note dated XXXX documented symptoms of XX are improved. XXXX is long standing and preceded XX XX by over a XX. The claimant expressed interest in XX discussed. Orders to increase XXXX, to target XXXX was given at time of visit. Follow up date of service XXXX discussed the claimant XX XX of XX, XX days after increasing XXXX. XX noted around XX and XX no significant abnormalities. At that visit, the claimant reported XXXX helped XXXX, but still complained of XX to XX. XX score was XX, same as last visit. Recommendations discussed to reduce use of

XXXX XX to XXXX. Follow up visit note dated XXXX revealed the claimant noted went to XX study, which messed XX up for a few days "XX and XX pain" XX bothered XX. The claimant reported "XX". When asked who "XX", speaking of XX of treatment for XXXX. "XX". Letter was given at last visit for XX recommendations, noted XX, XXXX, stated after coverage determined, will get treatment for XXXX. Recommendation plan was to try XXXX for XX, keep other 2 meds the same. Pharmacy request for refill XXXX by mouth XX daily as needed for XX and XXXX. Initial utilization review determination dated XXXX denied because the use of XXXX are not supported in the current evidence-based guidelines for treatment of chronic pain or for XX. Reconsideration appeal dated XXXX upheld the denial.

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

Based on the clinical information submitted for this review and reviewing the Official Disability Guidelines (ODG), the request for XXXX by mouth XX daily as needed is not medically necessary.

XXXX is a XXXX and according to ODG, XX. In this case, the review of records revealed prior trial of XXXX but XX of prior use of XXXX is not documented. Also, there is no documentation as to when it was started and ended by previous physician. The chronic use of XXXX is not supported in the current evidence based medical literatures/guidelines, and there is no evidence that long-term use of XXXX is safe and effective. Thus, the request of XXXX is not medically necessary and the request is non-certified. Since abrupt discontinuation is known to result in XX XX, XX XX should be considered and initiated.

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

XX