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Date notice sent to all parties: 11/12/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XXXX XX months for XX

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

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☐ Upheld (Agree)

X 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.

XXXX XX months for XX – Overturned

PATIENT CLINICAL HISTORY [SUMMARY]:
On XXXX, a request to continue XXXX therapy for XX for the XX was certified. XXXX evaluated the patient on XXXX. XXXX had done well with the XXXX XX and had a recent XX the XX week, as XXXX was due for a new set of injections. XXXX still had some mild XX and estimated the decrease in XX frequency at about XX%. XXXX had about XX XX per week, down from the previous XX. XXXX was currently on XXXX. XXXX recommended additional XXXX injections, which were requested on XXXX. On XXXX, the patient informed XXXX that XXXX had significant XX, close to XX%, with the use of XXXX XX. At times, XXXX could go XX without a XX, but once the XXXX wore off, XXXX XX returned. XXXX had mild XX on exam and the remainder of the exam was essentially within normal limits. XXXX injections were performed over the XX XX. On XXXX, XXXX had returned on XXXX with improvement in XX frequency and duration. The patient returned on XXXX after XXXX was unable to obtain XXXX the XX before. XXXX had an increase in XX frequency and duration.

XXXX also had developed a XX XX that had been occurring off and on. XXXX felt XXXX was the only thing that controlled XXXX XX. XXXX received additional XXXX injections at that time in the same areas as previous. As of XXXX, XXXX was doing very well and the XXXX was working great. XXXX was using less XX medication and had not had any emergency room visits. On XXXX, XXXX requested authorization for XXXX XX units every XX months, which the carrier denied on XXXX. On XXXX, XXXX addressed a letter of appeal, noting XXXX response to prior XXXX was over XX%. Prior to XXXX injections, XXXX XX frequency was approximately XX XX per month with severe XX. On XXXX, an appeal request was made for the XXXX XX units every XX months, which the carrier again denied on XXXX. The patient addressed a letter on XXXX.

XXXX indicated XXXX sustained a XX on XXXX when XXXX suffered a XX, loss of XX, and had XX. XXXX noted XXXX suffered from severe XX XX without XXXX quarterly XXXX injections. The patient filed a XX with XX on XXXX.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the documentation reviewed, XXXX injections were certified for this patient on XXXX. As of XXXX, XXXX estimated the decrease in XX frequency was about XX-XX% and XXXX had about XX XX a XX, which was down from XX. It appeared XXXX injections were performed at that time. As of XXXX, XXXX noted XXXX XX frequency was improved by about XX% and XXXX frequency was XX every XX of XX. At times, XXXX could go weeks without a XX, but once the XXXX wore off, XXXX XX increased. XXXX injections were again performed and as of XXXX, XXXX XX had improved in frequency and intensity, although the returned at the end of the XX XX cycle. On XXXX, XXXX noted the patient was unable to obtain XXXX the XX before and had an increased in XX frequency and intensity. XXXX felt XXXX was the only thing that helped XXXX XX. XXXX received the injections at that time. As of XXXX, XXXX indicated XXXX was doing very well and the XXXX was working great. XXXX was utilizing less XX medication and XXXX had not had any emergency room visits. On XXXX, a preauthorization request was submitted for XXXX XX units every XX months. On XXXX, an adverse determination was provided for the requested XXXX injections. On XXXX, XXXX addressed a letter of appeal noting that when the patient had XXXX injections, they lasted about XX months and XX week XX months. The XX weeks prior to XXXX re-injection, the XX frequency increases dramatically, occurring almost on a XX basis, averaging approximately XX per week. XXXX noted that prior to XXXX injections, the XX frequency was approximately XX XX per month with severe XX. XXXX noted the patient's response to XXXX injection was over XX%, which had been documented previously. On XXXX, an appeal preauthorization request was submitted for the XXXX injections. On XXXX, the carrier submitted another adverse determination for the requested XXXX injections.

Per the ODG regarding criteria for XXXX for prevention of chronic XX XX, an initial XX week trial is felt to be appropriate if the all of the following criteria were met: diagnoses with chronic XX XX, more than XX XX per month with XX lasting XX XX a XX or longer, and no response to at least XX prior first line XX XX XX medications. For continuation of XXXX treatment for ongoing prevention, the ODG notes XX XX frequency should be reduced by at least XX XX per month when compared to pretreatment average; or the duration was reduced by at least XX XX

per month when compared to pretreatment. The ODG notes that the XXXX injections should be discontinued if XX days reduced to less than XX XX a month over XX consecutive months, as this qualifies as an episodic XX, not covered for XXXX. The patient apparently suffered a traumatic XX XX in XXXX where XXXX suffered a XX, XX of XX, and had several XX. Based on the documentation reviewed at this time, XXXX had received substantial benefit from the XXXX injection therapy provided to XXXX thus far. XXXX XX frequency was reduced by at least XX XX per month when compared to when XXXX does not receive the XXXX injections, which is a criteria of the ODG. The ODG also notes that XXXX A continues to relieve XX XX when given over the long XX, according to a retrospective analysis of patients with chronic XX treated for XX treatment cycles, XX weeks apart. Therefore, the requested XXXX injections XX units every XX months is appropriate, medically necessary, and in accordance with the ODG and the previous adverse determinations should be overturned 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)**