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November 12, XX

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:
American Board of XX Medicine

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

☒ Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XXXX who was diagnosed with XX XX XX (XX) and XX at XX-XX and XX-XX, XX and XX degenerative XX disease, XX and XX.

From XXXX, the patient was admitted at XXXX for treatment of symptomatic XX and XX at XX-XX and XX-XX. On XXXX, the patient underwent XX XX XX and XX at XX-XX and XX-XX level. Postoperatively, the patient healed well. XXXX was discharged in a stable condition.

From XXXX, the patient was seen by XXXX. The patient was continued on conservative management for XX pain.

On XXXX, x-rays of the XX XX showed postoperative XX at XX, XX and XX, XX XX and XX disease in the XX XX XX. There was XX at XX-XX.

On XXXX, XX of the XX XX showed interval XX XX fusions at XX-XX and XX-XX. There was a mild XX of the XX XX XX though this was from XX to XX. Mild XX XX displacement was present to the levels of reversed XX. XX of the XX XX from the same date showed no signs of focal XX replacing process from XX to XX. The XX terminated at the level of the XX-XX interspace and tapered normally.

From XXXX, the patient was seen by XXXX for follow-up evaluations. The patient continued

to have increased pain in the XX. On XXXX, the patient underwent XX XX XX with XX, XX at XX-XX and XX-XX and XX XX XX to XX by XXXX.

On XXXX, an XX of the XX XX showed prior XX from XX through XX which appeared solid. There was some straightening of the XX XX in this region. There was XX-XX moderate XX protrusion. An XX of the XX XX from the same date showed diffuse XX bulging at several levels. At XX-XX, there were prominent XX. There was XX XX which caused mild XX XX recess XX.

From XXXX, the patient was admitted at XXXX. On XXXX, the patient underwent XX to XX XX XX of XX, XX, XX and XX XX roots XX, XX to XX XX XX, XX to XX XX XX fixation by XXXX.

XXXX, XX XX XX performed at XXXX showed status post XX and XX from XX through XX with enhancing XX XX or XX, especially at the XX-XX and XX--XX levels. There was a fluid collection in the XX tissues XX to the XX XX at the XX and XX levels.

From XXXX, the patient was seen by XXXX for follow-up evaluations. On XXXX, the patient underwent XX XX XX of XX including the XX-XX XX and the XX-XX XX and XX XX XX with XX XX by XXXX. During this period, the patient underwent x-rays of the XX XX.

On XXXX., completed a Required Medical Examination (RME). The record is poorly scanned and partially legible.

From XXXX, the patient was admitted at XXXX for the evaluation of problem with XX XX and severe XX XX XX pain. XXXX was discharged in a stable condition.

On XXXX, the patient underwent computed XX-guided XX drainage.

From XXXX, the patient was evaluated by XXXX. On XXXX, the patient underwent a XX XX scan. Per an office visit note dated XXXX, the patient was stable but continued to have pain in the XX XX XX.

On XXXX., completed an RME.

On XXXX the patient underwent a functional capacity evaluation (FCE). The patient met all requirements for XX.

On XXXX, a XX XX study was performed. The patient had XXXX pump XX to the XX XX causing increased XX.

From XXXX, the patient was seen by XXXX, for increased XX. The patient was advised to contact XXXX for pain management.

On XXXX, completed a peer review.

From XXXX, the patient was seen by XXXX. On XX, the patient underwent an XX of the XX XX. On XXXX, the patient underwent x-rays of the XX XX. Per office visit note dated XXXX, the patient was XX XX. XXXX had a XX XX.

From XXXX, XXXX, evaluated the patient for chronic XX and XX XX pain. The patient was recommended XX and Pain Management.

On XXXX, saw the patient for increased temperature. The patient was scheduled for XX for XXXX XX issues. The vitals revealed XX XXXX in XX position and XXXX in XX position. The temperature was XXXX. The diagnoses were XX of questionable XX, XX, XX XX pain, XX and history of XX XX disease. Labs, XX x-rays, XXXX, and XX XX diet were recommended. XXXX considered adding additional XX medication if XX XX remains above XXXX.

On XXXX noted the patient did not have any further XX, and the diagnostic study was normal. The XX was XXXX in sitting and XXXX in standing position.

On XXXX performed XX XX and XX XX XX XX (XX) with XXXX. The pre-procedure XX was XXXX, and postprocedure XX was XXXX. The patient was given XXXX.

On XXXX saw the patient for follow-up of XX. Current medications included XXXX. Vitals noted XX at XXXX. XX exam revealed faint XX. XXXX was prescribed and labs were ordered.

A discharge summary dated XXXX indicated the patient was admitted from XXXX. XXXX was admitted for further evaluation of XX and XX. XXXX was started on intravenous antibiotics and XX XX. XXXX required packed XX for XXXX XX. XXXX was seen by XXXX in XX followup. XX of the XX was ordered. XXXX was seen by XXXX in XX consultation and underwent XX and was found to have XX XX and XX. XXXX was placed on XXXX. It was recommended XXXX XXXX be discontinued. XXXX was placed on XXXX before meals and at bedtime. XXXX was seen by XXXX in XX consultation. XXXX initially was continued on XXXX. XXXX initially had an elevation of XX and creatinine which resolved with intravenous hydration. XXXX. XXXX was transfused with XX. XXXX was started on XX along with the XX XX. XX of the XX XX showed XX changed with XX screw extending from XX through XX and XX being XX through XX XX levels prior to XX at XX. XX of the XX XX showed superior XX XX XX through XX which was not felt to be acute. At the time of discharge, labs had improved. Discharge medications were XXXX. It was considered that if the XX XX XX rises above XXXX XX could be started from XXXX.

On XXXX, completed a Designated Doctor Evaluation. XXXX opined that the extent of the injury was failed XX syndrome, post XX syndrome of the XX and XX XX, XX fracture of the XX, post XX and XX/XX history.

On XXXX, XXXX noted the patient presented in a XX wearing XXXX XX. XXXX was XX to XX and spends most of XXXX time in the XX. XXXX believed that the XX was clearly related to the XX XX since the injury. XXXX was discontinued due to XX bleeding, which in turn was

related to XX. The patient was unable to find any XX as XXXX case was under XX XX. XXXX was referred to XXXX for medical conditions.

From XXXX, XXXX evaluated the patient for follow-up evaluations. The patient was XX to a XX.

On XXXX, a XX XX scan showed XX.

On XXXX, saw the patient in follow-up evaluation. The past medical history included XX, XX XX, XX, XX, XX and XX. Follow-up with Pain Management was recommended.

On XXXX, CT of the XX XX showed multiple XX XX involving XX, XX, XX, XX XX most severe at XX. There was XX XX disease in the XX XX with XX. CT of the XX XX showed status XX XX placement from XX through XX XX an XX compression fracture. There were XX XX screws and XX plates extending from XX through XX. The XX XX XX screw extended into the XX XX aspect of the XX XX and the XX plate was displaced XX probably reflecting motion. The XX XX XX screw also crossed the XX XX. There was suspected XX XX XX screw to slightly cross the XX XX.

From XXXX evaluated the patient in follow-up visits. The patient continued to have severe XX and XX pain. XXXX had some XX which was related to pain. It was inadequately controlled with XX dose of XXXX. XXXX XX was recommended.

On XXXX noted the patient had repetitive motion injury to XX and XX in XXXX with resultant XX and XX XX XX. The patient had numerous surgeries of both XXXX XX and XX on numerous occasions. The patient had difficulty with infections of the XX. The patient had the complication of XX. The patient spent the majority of XXXX time in XX secondary to pain. When out, XXXX XX. The patient had a significant amount of pain. XXXX had a XXXX pump. The patient was utilizing XXXX. The diagnoses were XX secondary to XX XX XX disease (XX) and multiple surgical operations, XX, XX, XX and XX secondary to XXXX use. XXXX felt there was no evidence of XX or attempts not to perform at the best level. The patient needed physical XX to do all of XXXX XX XX except for XX XX.

On XXXX, the patient was seen by XXXX for pain management. The current medications included XXXX.

On XXXX, the patient was admitted at XXXX where XXXX underwent XX which showed XX XX but otherwise normal study. XXXX also underwent x-rays of the XX which showed an XX XX. (Incomplete documentation)

On XXXX, the patient was seen by XXXX for XX, XX disease of the XX and generalized XX. The associated symptoms included XX and elevated XX XX. Recently, when XXXX pain worsened XXXX, and XXXX had to go to the Emergency Department to get this under control. The current medications included XXXX. On exam, XXXX XX XX was XXXX. XXXX opined as XXXX has been intolerant of higher doses of XXXX was added the patient XXXX regimen, but there was concern about XXXX long-term risk with XXXX XX XX. The patient

was advised to stay off the XXXX which in the long term was not a good choice for XX XX control. XXXX was refilled. XXXX was also advised to visit the Emergency Department if XXXX had another XX of elevated XX XX.

On XXXX, the patient was seen by XXXX for a follow-up evaluation. The XX XX was XXXX. The patient was advised to continue the current XX medications.

From XXXX, the patient was seen by XXXX for follow-up evaluations. On XXXX, it was noted that the patient had struggled with XX pain from XX XX and XX disease of the XX and this led to XX XX. XXXX had XX which had also been an issue directly related to how severe was XXXX pain. XXXX was prescribed to control both XXXX XX and XX. On XXXX, it was noted that XX was clearly secondary to pain. XXXX XX XX was well controlled by XXXX. On XXXX, a correspondence indicated in-home heated XX was recommended. On XXXX, XXXX opined XXXX XX XX was controlled only if XXXX pain was better. The treatment recommendations included XX XX and continuing current medications.

On XXXX., completed peer review and opined the XX XX
was not medically necessary.

On XXXX, XX swallow study was essentially unremarkable.

On XXXX completed peer review and recommended a trial of XX therapy.

On XXXX, a correspondence by XXXX indicated the patient's condition XX over the time. The patient had difficulty with XX as a consequence of XXXX XX XX controlled pain. The patient's injury did affect XXXX XX extremities significantly, in that XXXX had XX related to XX compromise from XXXX XX disease. XXXX was XX XX to work.

On XXXX, a request for a XX XX at XX was placed by XXXX.

Per IRO dated XXXX, the denial for the XX XX was upheld.

From XXXX, the patient was seen by XXXX. The patient was advised to continue the XX regimen. XX therapy was recommended.

On XXXX, x-rays of the XX XX showed extensive postoperative change and degenerative XX and XX disease.

On XXXX, correspondence from XXXX indicated the patient was completely disabled.

On XXXX, the patient underwent XX with XX at XXXX.

On XXXX, an XX of the XX XX with and without XX showed reversal of the usual XX curvature. There was extensive XX XX from XX-XX through XX-XX. The XX were solid. At XX-XX, flattening of the XX XX was seen. There was prominent XX joint XX XX greater than XX with XX XX of the XX and XX XX of the XX XX. There was solid XX XX at XX-XX,

XX-XX and XX-XX levels. There was flattening of the XX XX with mild XX XX XX. There was mild XX XX XX at XX-XX. There was XX XX XX with XX flattening the XX XX with mild XX XX XX. An XX of the XX XX from the same date showed XX XX. There was evidence of XX. There was XX XX XX at XX-XX and XX-XX with flattening of the XX XX.

On XXXX, an XX of the XX XX showed XX XX fracture of XX. A XX XX of XX was seen. An XX XX XX was noted bridging the XX XX and extending from the body of XX through. XX. There was from the XX-XX through XX-XX levels a XX XX with a XX XX and XX fixation. XX XX screws from XX through XX were noted. At XX-XX, a XX.0 mm XX XX flattened the XX XX. At XX-XX, a XX.0 mm XX XX with mild XX XX narrowing was seen. At XX-XX, an XX XX XX with mild XX XX XX was identified.

From XXXX, the patient was seen by XXXX for follow-up evaluations. The patient was XX XX. On XXXX, it was noted that the patient was functionally close to being XX.

On XXXX, a telephone note from XXXX., indicated the patient had severe XX XX XX up to XXXX and increasing XX pain and XXXX.

From XXXX, the patient was evaluated by XXXX for follow-up evaluations. On XXXX, it was noted that XX was XX. XXXX had a really XX XX lately with an infection of XXXX pain XX and it turned out XXXX pain XX was leaking, and XXXX was not getting much of XXXX pain medication and had inconsistent delivery of XXXX. Since this had been addressed and the XX had been replaced, XXXX had done better from the standpoint of XX XX and had much less lability to XXXX XX XX. XXXX still had significant pain which was severe XX/10 allover. It was XX in quality and had been occurring XX for XX. On XXXX, the patient underwent XX XX space XX XX. The patient was advised to continue XX medications

On XXXX, the patient underwent a XX scan which revealed stable XX.

Per an E-mail dated XXXX, the patient's XXXX reported XXXX XX XX was getting XX, and XXXX was getting XX. The XX XX noted on XXXX. XXXX stated when the patient takes the XX XX pill XXXX XX goes down but XXXX XX XXXX XX the pill and XXXX did okay for the XX day or so and now it was XX XX again.

On XXXX performed a XX evaluation for XX pain and XX. The patient reported that XX days ago XXXX XX and XXXX. XXXX developed severe XX XX, and XX XX increased significantly to XXXX. XXXX was given XXXX and placed in XX, and after an XX XXXX XX XX improved. XXXX had some associated XX of XX. XXXX had difficulty controlling XX XX and it particularly went up quite a bit when XXXX was in pain. XXXX had XX XX pain secondary to XX disease and was on XXXX XX. XXXX had been diagnosed with XX in XXXX. XXXX had recurrent XX in XXXX. XXXX discontinued XXXX.

On XXXX, a XX was normal. The indication for the study was XX pain.

On XXXX, XX report was documented. The study showed trace XX XX and XX XX XX. The XX XX was XXXX. The study was otherwise unremarkable.

On XXXX, a correspondence by XXXX indicated that as a consequence of the patient's pain, XXXX XX XX had been very difficult to control. In particular, when XXXX had painful episodes/flare-ups, XXXX XX XX had been quite XX despite the addition of XX and XX therapy.

From XXXX, the patient was seen by XXXX for persistent XX pain all over and XX. On XXXX, XXXX recommended to continue follow-up with XXXX as XXXX had already made a significant impact with just adding XX-XX. XXXX also opined the patient's health problems were worse also because of the XX of getting the appropriate care as XXXX continued to struggle to get what needed. The patient was advised to continue exercises in the XX, but XXXX endurance was XX XX now with XXXX near XX XX and XXXX XX.

On XXXX, the patient was seen by XXXX for a follow-up evaluation. The patient's XX XX was most of the time between XXXX XX. XX showed XX XX, first-degree XX block. The diagnoses were XX and XX. The patient's XX was well controlled with the current medications. XXXX was prescribed.

On XXXX, site visit from XXXX was documented.

On XXXX, the patient was seen by XXXX for ongoing issue of XX XX of both XX extremities. The treatment recommendations included XX XX XX and XX surgeon XX.

On XXXX, x-rays of the XX showed no evidence of fracture. X-rays of the XX showed XX changes in the XX XX.

On XXXX, the patient was seen by XXXX., for evaluation of XX with XX XX and XX due to XX from XX XX. XX XX treatment was recommended.

On XXXX, XXXX noted increasing XX extremity XX and XX XX. XXXX had occasional XX of XX. In certain positions, XXXX had a hard time catching XXXX XX. The diagnoses were XX, XX and XX. XXXX discontinued XXXX and started XXXX.

On XXXX, XXXX saw the patient in a follow-up visit. There was improvement in the XX. XX showed XX XX, first-degree XX, nonspecific XX and XX XX. The diagnoses were XX and mixed XX. XXXX recommended follow-up with a XX for further work-up for complaints of significant XX and discomfort.

From XXXX, the patient was seen by XXXX for follow-up evaluations. On XXXX, it was noted that the patient clearly had XX. XXXX continued to have XX pain all over. XXXX XX XX was XXXX. XXXX recommended follow-up with XX for management of XX, continuing current medications and XX therapy.

From XXXX, the patient was seen by XXXX for follow-up evaluations. XXXX had persistent episodes of uncontrolled XX XX and XX pain. Per office visit note dated XXXX, the patient was XX to XX changes and was unable go outside into the XX because of the XX XX of the XX

as it elevated XXXX XX XX. X-rays of the XX XX dated XXXX, showed status post XX through XX XX with stable XX changes. X-rays of the XX from the same date showed XX. X-rays of the XX XX showed XX post XX through XX XX with XX and XX XX XX stable.

On XXXX evaluated the patient for a follow up. The patient was independent with XXXX self-care activities of XX. XXXX opined the patient needed a XX XX XX XX that was XX XX for both XX and XX. The patient needed to have maintenance ROM daily for all XX extremities. The patient had XX secondary to XX XX injury.

On XXXX evaluated the patient for the XX of wear and erosion from XX XX.

On XXXX, a correspondence by XXXX indicated the patient was advised to have XX as an outpatient procedure XX condition.

On XXXX, the patient underwent XX at XXXX.

On XXXX, the patient was seen by XXXX for pain management. XX with reprogramming was recommended. XXXX dose was increased.

Per correspondence by XXXX, the patient was seen for XX by XX and XX.

On XXXX, the patient underwent XX session at XXXX.

Per utilization review by XXXX, a request for the XX was not medically necessary.

On XXXX, the patient attended XX session by XXXX.

On XXXX, a letter by XXXX indicated the patient's XX XX became XX when XXXX was under significant XX XX or had significant XX and the elevation of XXXX XX XX was XX to XXXX health.

On XXXX, XXXX evaluated the patient for XX while lying flat and XX XX XX. XXXX would get XX pain which caused XX pain and XX XX pain when XXXX was XX. The patient stated XXXX would XX, and XXXX felt when XXXX had an elevated XX rate XXXX XX XX would begin to elevate. This usually happened at XX. XXXX would awaken with XX XX XX(XX). The medication list included XXXX.

On XXXX, labs from XXXX.

On XXXX, XX XX from XXXX showed mildly XX XX XX, significant XX disease and the XX XX XX XX was XXXX.

On XXXX, the patient attended XX session at XXXX.

On XXXX, the patient was evaluated at XXXX. The patient presented for XX reevaluation. The patient continued to be XX XX with no functional movement of the XX XX and limited use of

the XX XX. The evaluator opined the patient needed XX hours a XX, XX XX care for XX XX injury and the diagnosis of XX XX. It was felt it would be beneficial for the patient to have a XX for XXXX to XX and XX each XX. The patient had a problem with XX XX. The patient needed to be in a XX-XX XX at all times.

On XXXX, a request for XX XX was denied.

On XXXX, XXXX recommended the patient to continue healthcare and ordered an XX of the XX XX. The current medications included XXXX

On XXXX, the patient was seen by XXXX in a follow-up visit. The patient continued to XX with regard to XX status. XXXX had XX ability to get around in a XX due to XX XX. XXXX was unable to do XX therapy. XXXX continued to have severe XX and XX pain. The treatment recommendations included continuing current medications and follow-up with XX specialist.

On XXXX, the denial for XX XX was upheld.

Per utilization review dated XXXX, a request for XX was denied.

From XXXX, the patient was seen by XXXX for follow-up evaluations. On XXXX, the patient had classic flare-ups with very XX XX XX. Some of XXXX episodes of dramatically increased XX XX, XX, XX, and XX had been associated with both XX and XX. XXXX triggers appeared to be XX. It was felt the patient would benefit from XX therapy. XXXX XX XX was XXXX. XXXX weight was XXXX. During this visit, XXXX had significant episode of XX and XX, which was much more prominent with XXXX XX in the XXXX and XXXX pulse in the XXXX XX while XXXX was XX and XX. XXXX agreed with the diagnosis and treatment plan by XXXX. The treatment recommendations included XX XX, continuing current medications and follow-up with XXXX.

On XXXX, XXXX noted the XX XX was XXXX. The XX would spike when XXXX got XX. XXXX had worsening XX extremity XX. XXXX had XX when lying flat. The patient was started on XXXX.

On XXXX, correspondence by XXXX indicated the patient had complications which included XX XX, XX and XX XX XX. XXXX was XX to a XX and functioning at the level of XX. XXXX had suffered from a wide range of XX XX which was difficult to control. XXXX was in support with a diagnosis of XX XX by XXXX and XXXX proposal of ongoing care.

On XXXX, XXXX noted the patient developed work-related XX disease and XX XX. This led to XX compromise and XX. Complicating all this was that XXXX was on extended XX XX from XXXX work-related injury which led to XX and subsequent XX XX which further complicated the XX. The XX clearly caused XX XX manifested by XX, XX, XX and XX. The patient was recommended gentle XX in a XX. The patient had significant changes in XX XX medicine which made a lot of sense.

On XXXX, XXXX opined the patient's widely fluctuant XX XX would certainly be most

consistent with XX XX.

On XXXX, XXXX noted the patient continued to struggle with XX frequent XX XX consistent with XX. The diagnoses were XX XX disease, XX XX disease, XX, XX XX, XX XX XX XX, XX, XX, essential XX, XX XX/XX syndrome, XX and XX. XXXX recommended medication adjustment with XXXX.

Per correspondence dated XXXX, XXXX opined the patient was XX.

On XXXX, an XX of the XX XX showed moderate reversal of the usual XX. At XX-XX, there was a XX mm XX XX flattening the XX XX with moderate XX of XX foramen.

On XXXX, XXXX presented for follow up of XX leading to XX and XX XX. The diagnoses were XX, XX XX, XX XX disease, XX XX XX XX and XX. XXXX continued XXXX-XXXX.

On XXXX, the patient was seen by XXXX for evaluation of XX XX. At home, the patient's XX XX was better controlled but XX XX XX to spike. The treatment recommendations included continuing follow-up with XXXX, XXXX and continuing XX therapy.

On XXXX, XXXX evaluated the patient for persistent XX and XX. The patient had XX XX secondary to XX XX, XX, and chronic XX XX XX. XXXX had chronic XX XX XX with worsening of XX and XX in XXXX XX the XX. XXXX had XX, but it was not worse than before. XXXX continued to have chronic XX pain and XX XX pressures. XXXX XX XX increased when XXXX was having pain or when XXXX was XX. XX showed XX XX, first-degree XX block, XX XX, XX XX XX and prolonged XX. XXXX were continued along with other current medications.

On XXXX, XXXX saw the patient for medications management. XXXX opined XX and XX XX XX disease after injuries led to XX and XX XX. The treatment recommendations included continuing current medications and follow-up with XXXX for consideration of options for XX XX.

On XXXX, XXXX evaluated the patient for XX, XX and XX. The patient underwent XX that showed XX XX, first-degree XX block and XX XX XX. The diagnoses were XX XX, XX XX, mixed XX, history of XX, XX XX, history of chronic XX disease and adult XXXX. The patient was encouraged to exercise and provided lifestyle education regarding diet. The final medication list consisted of XXXX.

On XXXX, XXXX evaluated the patient for a XX-month followup. XXXX was seeing XXXX for pain management and felt XXXX was making XXXX XX. XX showed XX XX, first-degree XX block, XX bpm, normal XX. The diagnoses were XX XX causing XX XX, history of XX, mixed XX, history of chronic XX disease and XX XX. The final medication list included XXXX

On XXXX, XXXX evaluated the patient in a follow-up visit. XX showed XX XX, XX XX,

first-degree XX block, XX bpm, XX XX XX and nonspecific XX XX abnormality. The patient was provided lifestyle education regarding diet. The final medication list consisted of XXXX

On XXXX, XXXX evaluated the patient for a XX-month follow up. The patient had XX XX secondary to XX XX, chronic XX extremity XX which had improved and XX. XXXX had occasional XX, but it was not worse than before. The patient continued to have chronic XX pain and XX XX XX. XXXX was scheduled for an XX XX stimulator (XX) placement. The patient's XX XX would increase due to pain or XX to XX. XXXX had no XX discomfort suggestive of XX. XX showed XX XX, first-degree XX block, XX bpm, XX XX XX and nonspecific XX abnormality. The diagnoses were XX XX, history of XX, XX XX, mixed XX, extremity XX, history of chronic XX disease and XX XX XXXX. The patient was encourged to XX and was provided education regarding XX. The patient was started on XX. The medication list included XXXX

Per Utilization Review dated XXXX, the request for XXXX was denied based on the following rationale: *"No, the request for XXXX, a XX XX lowering medication, is not medically necessary, medically appropriate, or indicated here. XX. Here, no explicit discussion of medication XX XX insofar as the XXXX in question was concerned. There were no clinical progress notes attached to* XXXX, *request for XXXX an issue. It was not clearly stated or clearly established that ongoing usage of XXXX was or was not proving beneficial regarding ameliorating the claimant's issues with XX. Hence, the request is not medically necessary. Therefore, the request for* XXXX, *is not medically necessary."*

The request for XXXX was denied based on the following rationale: *"Similarly, the request for XXXX, a XX-lowering medication, is likewise not medically necessary, medically appropriate, or indicated here. While ODG's XX Chapter XX topic acknowledges that claimants with XX as was/is present here. XX. Here, however, no recent progress notes were attached to the request for authorization. The historical notes on file failed to outline whether or not the ongoing usage of XXXX had or had not proven beneficial regarding ameliorating issues with XX. Hence, the request is not medically necessary. Therefore, the request for XXXX is not medically necessary."*

The request for XXXX was denied based on the following rationale: *"Similarly, the request for XXXX, a XX-lowering medication, is likewise not medically necessary, medically appropriate, or indicated here. As noted in ODG's Chronic Pain Chapter medications for XX and Chronic Pain topic, a record of pain and function with the medication should be recorded. Here, however, no recent progress notes were attached to the request for authorization. It was not clearly stated or clearly established that ongoing usage of XXXX had or had not proven beneficial. Hence, the request is not medically necessary. Therefore, the request for XXXX, is not medically necessary."*

The request for XXXX was denied based on the following rationale: *"The request for XXXX, a XX XX XX medication, is likewise not medically necessary, medically appropriate, or indicated here. While ODG's XX Chapter XX Treatment topic acknowledges that XX XX lowering medications are, in fact, recommended to optimize XX XX management in claimants with XX, this recommendation is likewise XX. Here, however, no clinical progress notes were attached to*

the request for authorization. By definition, no discussion of medication efficacy transpired. It was unclear, whether or not ongoing usage of XXXX was or was not proving beneficial in terms of controlling the claimant's XX XX. Hence, the request is not medically necessary. Therefore, the request for XXXX, is not medically necessary."

The request for XXXX was denied based on the following rationale: *"Finally, the request for XXXX, a XX, is likewise not medically necessary, medically appropriate, or indicated here. While ODG's XX Chapter XX Treatment topic acknowledges that XX XX management should be optimized in claimants with XX. XX. Here, again, no recent progress notes were attached to the request. It was unclear whether or not ongoing usage of XXXX was or was not proving beneficial in terms of controlling the claimant's XX XX. Hence, the request is not medically necessary. Therefore, the request for* XXXX*, is not medically necessary."*

Per the correspondence dated XXXX, XXXX was notified about the denial.

On XXXX, XXXX reported the patient was being followed for XX XX secondary to XX XX. The patient had chronic XX XX XX and mixed XX. The patient's XX XX would XX when XXXX gets XX. The patient was placed on XXXX, but XXXX developed significant XX XX XX. In XXXX, the patient was started on XXXX because of inadequately controlled XX XX on XXXX. In XXXX, XXXX was placed on XXXX after XXXX was taken off the market. The patient was placed on XXXX in XXXX because of its XX benefits. The patient was taking XXXX for XX XX since XXXX because of XX. The patient preferred to take the XXXX because XXXX had difficulty XX the XXXX.

Per Reconsideration dated XXXX, the request for XXXX was denied based on the following rationale: *"The provided records did not include any updated clinical information to support the use of XXXX as reasonable or necessary. The* XXXX *evaluation that was previously reviewed did not specifically discuss the indications or efficacy of this medication for the work injury. The additional clinical information would be required in order to support the ongoing use of XXXX as reasonable or necessary. Hence, this reviewer, would not recommend certification for the request. Therefore, the request for XXXX, is not medically necessary."*

The request for XXXX was denied based on the following rationale: *"The provided records did not include any updated information to support the use of XXXX as reasonable or necessary. The* XXXX *evaluation that was previously reviewed did not specifically discuss the indication or efficacy of this medication for the work injury. Additional clinical information would be required in order to support the ongoing use of XXXX as reasonable or necessary. Hence, this reviewer would not recommend certification for the request. Therefore, the request for* XXXX *is not medically necessary."*

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for XXXX is not medically necessary."

The request for XXXX was denied based on the following rationale: *"The provided records did not include any updated clinical information to support the use of XXXX as reasonable or necessary. The* XXXX *evaluation that was previously reviewed did not specifically discuss the indication or efficacy of this medication for the work injury. Additional clinical information would be required in order to support the ongoing use of XXXX as reasonable or necessary. Hence, this reviewer would not recommend certification for the request. Therefore, the request for XXXX, is not medically necessary."*

The request for XXXX was denied based on the following rationale: *"This medication was not found on research. It is possible that this is typo for XXXX. However, this would need to be clarified. Hence, this reviewer would not recommend certification for the request. Therefore, the request for XXXX, is not medically necessary."*

On XXXX, XXXX was notified of the adverse determination.

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

The member was documented at the XX office visits on XXXX to have XX XX due to XX XX. The member had good XX XX control with XX pressures XXXX at those office visits while being treated with XXXX. All XX of these medications are FDA approved for treatment of XX.

The member was documented at the XX office visits on XXXX to have XX. XX XX also confirm a diagnosis of XX. XX panels between XXXX demonstrated a total XX between XXXX. The values in XXXX occurred while the member was being treated with XXXX. Both XXXX and XXXX are FDA approved for treatment of XX; XXXX is also FDA approved for treatment of XX.

In summary, the documentation does support medical necessity of XXXX.

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

Physicians Desk Reference, XX edition

Micromedex