

*Magnolia Reviews of Texas, LLC*

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09/26/2018

**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:**

MD, Board Certified PM&R

**REVIEW OUTCOME:**

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

Upheld (Agree)

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]:**

The claimant is a XXXX who was injured on XXXX and had been followed for a chronic pain history for the low back in addition to anxiety. The claimant's medication history had included the use of XXXX. A recent clinical report was not submitted for review. The last evaluation was from XXXX which noted pain was not under control after discontinuing XXXX. The claimant did report some nausea and was using over-the-counters for persistent symptoms. The claimant had not received XXXX s at this evaluation. The physical exam noted limited lumbar range of motion. The use of XXXX was denied as topical medications were typically limited to neuropathic issues that had failed 1<sup>st</sup> line medications. There was also no indication for continuing chronic muscle relaxers for pain.

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

Regarding the use of XXXX continued on XXXX, the records did not include an evaluation for this date of service. There were no indications that the claimant had ongoing XX conditions. There was also no indication that the claimant had failed 1<sup>st</sup> line medications for neuropathic

pain to include anticonvulsants or antidepressants that would support the use of a topical spray like XXXX. Regarding XXXX, the use of muscle relaxers is not supported by current evidence-based guidelines for treating chronic musculoskeletal pain. There was no indication from the recent evaluations that the claimant had an exacerbation or flare up of musculoskeletal complaints that would support the use of this muscle relaxer. No exceptional factors were noted in the records that would otherwise support this medication as reasonable or necessary. Given these issues which do not meet guideline recommendations for either medications, it is this reviewer's opinion that medical necessity is not established, and the prior denials remain upheld.

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

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**