Vanguard MedReview, Inc.
101 Ranch XX Lane
Aledo, TX 76008
P 817-751-1632
F 817-632-2619

April 2, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX XX XX XX%

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 doctor of Anesthesiology/Pain Management with over 12 years of experience.

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]:
XX: Progress Note by XX. **HPI:** Patient is a XX year old XX XX XX involved in a work related injury on XX. XX was diagnosed and treated for chronic XX XX. XX was started on XX XX. Patient has elevated XX XX and had XX X. XX is complaining of pain located in the XX XX, XX greater than XX, XX XX numbness and XX. The pain began XX after XX XX XX XX on XX XX XX XX. The pain is described as sharp, shooting, weakness. The pain radiates to XX XX XX XX XX. The Medications have been utilized including muscle relaxants, non-steroidal anti-inflammatories. The relief is partial. **Assessment:** 1. Pain in XX XX, severe. 2. Pain in XX XX. 3. Pain in XX XX. 4. Pain in unspecified XX. 5. XX of XX XX. 6. XX of XX XX. 7. Weakness. **Treatment:** Hold XX XX tab. Stop XX cap, hold XX ER, Stop XX tab, Stop medi-XX w/XX XX, hold XX capsules, stop XX cap, hold XX tab, stop XX tab, start XX XX Dispensed XX XX%.

XX: Progress Note by XX. **HPI:** Patient states XX XX helps with the pain.

XX: UR performed by XX. **Rationale for Denial:** A handwritten letter provided for review noted that the patient was prescribed XX XX XX XX XX due to her XX XX, as XX XX would be detrimental to XX XX. The patient was evaluated for XX XX XX pain and weakness. Although the patient is XX to XX medication use, the rationale for the specific XX medication requested was not clearly indicated. The patient was being treated for XX XX pain and the guidelines specify that XX XX has not been evaluated for treatment of the XX. moreover, the guidelines specify that XX XX solution XX is FDA approved for XX of the XX. There were no exceptional factors noted to support the request outside the guidelines recommended. As such, the request for XX XX XX solution XX is non-certified.

XX: Letter of Medical Necessity by XX. I have prescribed and dispended to XX the XX medication XX XX XX XX solution. In an effort to provide XX with the most effective, minimally invasive methods of treatment for XX XX condition, I have prescribed and dispensed this medication to XX. XX XX XX XX XX is a medication that is only available with t physician's prescription and is medically necessary for this patient's medical condition that is secondary to XX XX injury sustained on XX. XX XX XX solution XX is a XX XX that is commonly used in XX conditions such as XX XX condition. This medication has the advantage of avoiding or minimizing XX XX of XX. By bypassing the XX system, and voiding secondary XX, XX and other complications as compared to XX forms of XX such as the XX forms. Like all the other medications that we have prescribed and/or dispensed to XX, this medication is a generic prescription medication that is reimbursable by all health insurance payors.

XX: UR performed by XX. **Rationale for Denial:** This case involves a now XX year old XX with a history of an XX claim from XX. The mechanism of injury is detailed as a XX injuring the XX XX XX. The current diagnoses are documented as XX XX, XX XX pain, XX XX pain, pain in the XX XX, XX XX XX, and XX XX XX. The letter of medical necessity on XX, documented XX XX XX is FDA approved for XX of the XX and there were no exceptional factors noted to support the request outside the guidelines recommended. According to the provided documentation, XX XX XX solution XX was recommended for this patient due to the patient's XX XX as XX medication will be XX to the patient's XX. This request was previously denied given the specific rational for XX medication was not clinically indicated and XX XX has not been evaluated for the treatment of the XX. Also, this medication is recommended for the treatment of XX for the XX and there were no exceptional factors provided to support this request for this patient. while the rational for XX medication was provided for this patient, there remains no evidence of XX for this patient and there was no clear evidence the XX XX has been evaluated for the treatment of the XX. As such, the medical necessity of this request was not established for this patient.

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

Based on records submitted and peer-reviewed guidelines, XX XX XX XX XX was recommended for this patient due to the patient's XX XX as XX medication will be XX to the XX XX. This request was previously denied given the specific rational for XX medication was not clinically indicated and XX XX has not been evaluated for the treatment of the XX. Also, this medication is recommended for the treatment of XX for the XX and there were no exceptional factors provided to support this request for this patient. While the rational for XX medication was provided for this patient, there remains no evidence of XX for this patient and there was no clear evidence the XX XX has been evaluated for the treatment of the XX. As such, the medical necessity of this request was not established for this patient. Therefore, this request is non-certified.

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**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **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)**