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Date notice sent to all parties: 01/09/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Prescription for XX
Prescription for XX

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

Board Certified in Orthopedic Surgery
Fellow of the American Associates of Orthopedic Surgeons
Fellow of the American Academy of Orthopedic Surgeons
Diplomate of the American Board of Orthopedic Surgery

REVIEW OUTCOME:

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

X Upheld (Agree)

☐ 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.

Prescription for XX – Upheld
Prescription for XX – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

XX. XX saw the patient on XX who complained of XX pain, XX, XX, and XX XX pain after being injured at work on XX. XX had been XX all day. XX currently rated XX pain at XX/10 in the XX to the XX. On exam, XX was in moderate XX and had obvious pain with movement. XX also had limited XX. XX had limited ROM in the XX and XX XX and tenderness in the XX through the XX. Sensation was grossly intact. The assessments were XX pain, XX pain, and XX pain. XX was advised to continue XX medications from the ER and return in 1 week. A XX MRI dated XX was unremarkable without acute XX fracture, acute XX extrusion, or XX. On XX, XX was in severe XX with XX XX with movement. XX was taking XX. and XX regularly with minimal relief. XX medications were refilled and XX was referred to neurosurgery. On XX, XX. XX reevaluated the patient and XX noted XX had constant XX pain rated at XX/10. XX took XX with moderate short term relief and XX with benefit. XX had limited ROM in the XX, XX back, and XX back. Sensation was grossly intact and XX were XX+. A XX MRI was ordered and XX medications were refilled. A XX MRI was then obtained on XX and was noted to be unremarkable with no acute compression fracture, acute XX extrusion, or XX. There was noted to be XX and XX changes, particularly at XX, XX, and XX. This was associated with XX and XX. XX then examined the patient on XX and diagnosed XX with XX pain and XX. XX recommended a possible XX and therapy. The patient was then initially evaluated in therapy on XX, but it was noted XX could not tolerate most special testing.

XX. XX followed-up with the patient on XX. XX was on XX, XX, and XX. XX noted XX was attending therapy prior to any injections being done and XX had completed XX sessions. XX noted XX XX pain went from XX/10 to XX/10 and XX still had XX pain rated at XX/10. XX noted however benefit from XX medications. XX exam findings were essentially unchanged and XX medications were refilled. XX reevaluated the patient on XX. XX XX pain shot into XX shoulders and XX XX pain radiated to XX thighs and XX had completed XX sessions of PT with moderate improvement. The XX and XX MRIs were reviewed. XX noted on exam the patient had disproportionate pain, tenderness, and muscle weakness. An XX study of the XX was recommended to rule out radiculopathy. XX examined the patient on XX and recommended XX XX injections at XX and XX. The patient was then reevaluated in PT on XX and XX noted XX was awaiting a call from the injection doctor. XX was referred back to the doctor at that time. On XX and XX, the patient followed-up with XX. XX. The assessments were now XX pain, XX pain, XX, and XX. XX medications were refilled as of XX. On XX, XX was awaiting approval for the injections as recommended by XX. XX had completed PT and it was noted the XX was approved, but the XX was not. XX rated XX pain in the XX at XX/10 and in the XX at XX/10. XX was taking XX and XX with benefit. XX was noted to have limited ambulation and was in moderate distress with facial grimacing. XX XX was tender and painful with motion and there was tenderness through to the XX. XX was positive XX. Sensation was grossly intact and XX were XX throughout. XX and XX were refilled at that time and XX off duty status was continued through XX. On XX, an adverse determination was

submitted for the requested prescriptions of XX and XX with XX. XX then performed XX injections on XX. As of XX, XX high pain over the last week was XX/10 and XX lowest was XX/10. XX had slight improvement from the injections. XX noted there was no disc pathology per the XX MRI and the patient stated the majority of XX pain was from the XX all the way down. A multidisciplinary assessment with an XX was recommended and it was noted XX had minimal objective findings. On XX, another denial was provided for the requested XX and XX with XX. On XX, XX requested a multidisciplinary assessment with XX. The patient returned to XX. XX on XX. XX had pain rated at XX/10 and all of XX exam findings were unchanged from previous notes. XX and XX were refilled and XX would remain off work through XX.

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

The patient is a XX XX who reported developing XX, XX XX, and XX XX pain after XX at work on XX. XX was initially evaluated at XX and underwent a CT scan, which was reported as negative. XX subsequently sought treatment from XX on XX at XX. XX diagnoses were non-specific and noted to be XX pain. There was minimal physical examination performed and, upon review of the medical records, a paucity of objective physical findings. XX has undergone extensive evaluation and treatment to include medications, physical therapy, and XX XX facet injections without any objective evidence of clinical improvement based on the documentation reviewed. XX has subsequently undergone XX MRI scan, which documented early degenerative changes, but no frank herniated nucleus pulposus or neurological compromise. A XX MRI scan only revealed XX, but no evidence of neurological compromise. XX, on XX, noted that the exam findings did not correlate with the MRI scans. XX, on XX, documented XX XX. Again, XX reported, on XX, non-dermatomal distribution, global disportionate pain, tenderness, and muscle weakness. XX noted no significant improvement after XX XX facet injections on XX. XX noted minimal objective physical findings, increased pain behaviors, and diffuse complaints. The requested medications were non-certified on initial review by XX. on XX. This non-certification was upheld on appeal/reconsideration on XX by XX. Both reviewers attempted peer-to-peer multiple times with the treating provider without success.

Both reviewers cited the evidence based Official Disability Guidelines (ODG) as the basis of their opinions.

As discussed above, the medical documentation reviewed documented minimal objective physical findings and no evidence of acute injury on the XX and XX MRI scans. The evidence based ODG require, for continuation of prescriptive medication, documented objective evidence of clinical and functional improvement for continuation of those medications. There is no evidence of this documentation in the medical record. In fact, it appears the patient has XX XX to work in any capacity, despite objective physical deficits which would preclude return to work. XX is only indicated for short term use, less than XX weeks, per the ODG, not for

chronic indications. The ODG also indicates in most XX pain cases, they show no benefit beyond non-steroidal anti-inflammatories in pain and overall improvement. XX or XX is an XX XX and should be used with caution. It should be reserved for short-term sporadic use in a setting of acute injury or acute exacerbation of an underlying chronic problem. In regard to continuing XX, the ODG notes it is supported if the patient has returned to work and if the patient had improved functioning and pain. The request does not meet the criteria as outlined by the evidence based ODG, in my opinion. Therefore, the requested prescriptions for XX and XX are not medically necessary, reasonable, or supported by the evidence based ODG and the previous adverse determinations should be upheld 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)**