CASEREVIEW

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X: Evaluation Notes by X, MD
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X: UR performed by X, MD
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PATIENT CLINICAL HISTORY [SUMMARY]:
This is a X year old X who was injured on X. X was X when another worker XX the other X causing the claimant to XX X end resulting in X. Prior treatment has included X and X in XX and a X. X had X therapy before and X. X also underwent X, but they were only temporarily helpful. A X and X provided only temporary and limited improvement. Current diagnosis: X of the X region, X with X, and strain of X level.

On X, an official XX XX XX report was positive for X
On X, it was reported there was good pain control without any side effects with medications. X was also able to perform activities of daily living. There were no signs of medication misuse.

On X, X presented in follow-up for pain management. X had complaints of X. Medications included X pain.

On X, X presented with continued pain. X gait was normal. Examination of the X revealed decreased X. Examination of the X revealed severely X. There was a X. There was X distribution. Sensation was normal in the X. Motor was X and reflexes were X. A X was in place and a random XX XX was completed in the office. Medications included X. Recommended treatment plan included change the X to, start X, change X, change the X pain.

On X, X, MD performed a UR. Rationale for Denial: The dosing for this request of X is not specified. This patient was previously prescribed X. This is in addition to X. This would be

a total of X. The progress noted dated X states there is good pain control and increased ability to perform activities of daily living with this medication. There were no signs of misuse and XX XX XX has been consistent. However, without a specific dosing being requested, this request is not supported.

On X, X, MD performed a UR. Rationale for Denial: According to the Official disability Guidelines, X is recommended for a trail after failure of X, X and after a trail of X. It is not recommended as a X and is not for use as an as needed X, for pain that is X period. In this case, the patient continues to report X pain with radiation into the X with prior treatments that include X, X, X, X and short and long-acting X. X was listed as a medication for which the patient was instructed to discontinue and begin X twice daily, however, there is no objective documentation regarding response to the extended release X in order to determine if there is treatment failure with prior use of this medication. Therefore, the requested X supply is noncertified.

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

Determination: Denial of "X there is lack of clarification regarding dosing. Review of records documents stable chronic pain control on generic X Immediate Release X with follow up clinical history and exams demonstrating maintenance of activity level, without adverse side effects, without misuse, and appropriate XX XX XX over a period of X months (X). However there is no rationale provided for requested change in X particularly without report of increased pain level, without report of decreased activity level, and no previous trial of X dose.

It is this reviewer's understanding that this request to Texas Department of Insurance for an Independent Review has been generated by the claimant/patient regarding "X" However without corroborating clinical documentation from a prescribing medical provider, this dosing cannot be deemed medically necessary either. Therefore, the request, per TDI Notice of Assignment, of X is not found to be medically necessary.

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)**