Independent Resolutions Inc.

Notice of Independent Review Decision

Case Number: Date of Notice: 6/24/2019 5:36:00 PM CST

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records – X
- Physician Questionnaire –X
- Adverse Determination Letters –X
- Attorney Letters –X
- Diagnostic Data –X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X-year-old X who was injured on X, while participating in X. X was diagnosed with X. On X, X visited X, MD for a follow-up. X continued to have X pain into the X. The pain continued to limit X activities significantly. X was not able to XX XX to X because of pain and X. X denied any adverse effects from X ongoing medications. On examination, X was in moderate discomfort. There was moderate tenderness to palpation over the X and mild tenderness to the X noted, but with moderate tightness in these muscles as well as X, X. X had moderate tenderness over the posterior X at the X level X, but the X was much more tender than the X, which recreated X pain. A prior authorization request form was completed by Dr. X on X. X expected to use X related to X pain. It was documented that X was on X, which did help X XX and XX; however, it was denied. X allowed X to use X pain medication, which caused XX and XX. This allowed X to do activities of daily livings. XX XX XX dated X was positive for X, which was an inconsistent result. The treatment to date included medications (X) Per a utilization letter dated X, the request for X was denied by X, MD. Rationale: “In this case, guidelines note that anti-XX are not recommended for XX and XX secondary to chronic XX use. The claimant was noted to be using X

for years related to X ongoing XX and XX due to XX use; however, this medication is specifically indicated for acute use secondary to X treatment, as well as X use or X, which this individual is not documented as having. Consideration should be made to re-evaluate the use of X XX that are causing these side effects. Attempts to reach the provider for additional information were unsuccessful. Therefore, the request for X with one refill is non-certified." Per an adverse determination letter dated X, the prior denial was X. Rationale: "UR Determination from X for X with one refill was non-certified. It was documented that In this case, guidelines note that anti-XX are not recommended for XX and XX secondary to chronic XX use. The claimant was noted to be using X for years related to X ongoing XX and XX due to XX use; however, this medication is specifically indicated for acute use secondary to X treatment, as well as X use or X, which this individual is not documented as having. Consideration should be made to re-evaluate the use of X XX that are causing these side effects. Attempts to reach the provider for additional information were unsuccessful. Therefore, the request for X with one refill is non-certified. In this case, the provider is now stating in the medical records provided for review that this medication is for XX for XX, but no XX are reported and this is not indicated for XX for XX. Attempts to reach the provider for additional information were unsuccessful. Therefore, the prior denial is X". In an adverse determination letter dated X, it was documented that Dr. X was refusing to do peer-to-peer discussion.

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

The Official Disability Guidelines discusses X, noting this medication is not indicated for XX and XX due to chronic XX use. FDA approved labeling information for this medication recommends its use for XX and XX associated with X XX. The medical records suggest that this medication has been prescribed for XX due to chronic pain; neither the references would support an indication of this medication for that indication particularly on an ongoing basis. The medical

records do not provide an alternate rationale for an exception to the treatment guidelines.
Overall, for these multiple reasons, this request is not medically necessary and should be X.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL