Applied Resolutions LLC

Notice of Independent Review Decision

Case Number: Date of Notice: 7/8/2019 and amended 7/18/2019

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records –X

- Peer Review Reports –X
- Utilization Reviews –X
- Diagnostic Data Report–X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was helping to attach a X requiring. X was diagnosed with X. The associated diagnoses were X. X was seen X, PA /X, MD on X and X. On X, X presented for post X, X, X, X pain, and medication refills. The pain was rated X with medications and X without the medications. X had a long history of pain from a Worker's Compensation injury resulting in X pain and severe X as well as X. Following the injury, X had X. X was on X and X to X injury but tried to work as much as X could to help ends meet. X had a fall in X and X. X continued to have pain, it was better, but bothersome. The pain continued to be evident, but much improved since the X, but X X was exceedingly weakening. X had more X. On X examination, the range of motion was decreased including X. X test was positive. The X examination revealed restricted range of motion on the X. X test was positive and X test was positive on the X at X degrees. On back examination, X had X. The range of motion was decreased. The X was diminished significantly in the X. There was normal sensation for the X. On X, X presented for a follow-up. X continued to struggle with X ongoing complaints. The pain continued at X with medications and X without the medications. X was refilled. In a clinical note dated X, Dr. X documented that X would need X for an

extended period of time, and continue the X for X months. A XX XX screen dated X was positive and consistent for X. The treatment to date included medications (X) and X. Per a utilization review decision letter dated X peer review dated X, the request for ongoing use of X was denied by X, MD. Rationale: "Official Disability Guidelines discusses the 5 A's of XX management. XX are generally not recommended for X pain or for X diagnoses. This injured worker's combined XX use from both X and simultaneous use of X substantially exceeds the X XX threshold for risk of X/ X from ongoing X use. Moreover, there is extremely limited discussion of any specific functional benefit of X in this case. It is not clear that X options have been exhausted before continuing XX use. Overall, the rationale for continued XX use, as well as objective or even subjective benefits of continued X are unclear. This request is not medically necessary and should be non-certified." Dr. X recommended weaning of X. Per an adverse determination letter dated X and peer review dated X, the prior denial was X by X, MD. Rationale: "There is a request for reconsideration of X. The attached documentation does not demonstrate objective functional gains with ongoing use of this medication. No exceptional factors are noted. Therefore, this request is not medically necessary." Dr. X also recommended weaning of X.

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

Regarding X, the use of long acting XX can be considered as an option for the treatment of X pain after failure of multiple options for pain control. There is less evidence supporting the efficacy of XX medications in treating X pain as this class of medication loses its effect over a period of time. Escalation of XX to control pain is common and not recommended by the current evidence based guidelines. In this case, the specific efficacy of X is unclear as there are no clear functional improvements noted in the recent clinical reports as a result of the ongoing use of this medication. The claimant still reported very high pain scores above X even with medications. The records also did not include any recent risk assessments or

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XX XX screen testing for compliance measures as recommended by guidelines for long term use of XX medications. Given these issues which do not meet guideline recommendations.
Given the documentation available, the requested service is considered not medically necessary and the decision is 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

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☐ TMF SCREENING CRITERIA MANUAL