I-Resolutions Inc.

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

Periodic XX injection / XX XX mg #XX

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Anesthesiologist

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

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX. XX XX is a XX-year-old XX who was injured on XX. XX sustained an injury to the XX XX after XX a XX XX. The ongoing diagnosis included XX (XX.XX).

An MRI of the XX XX dated XX showed mild XX XX with no partial or full-thickness of XX XX XX. The interspace tendon was intact; however, there was severe diffuse fatty XX of the muscle XX. The etiology of the fatty XX was uncertain and might be XX in origin. There was extensive distal XX excision and XX with no narrowing of the XX space. There was minimal XX in the XX XX. The XX XX screen dated XX was documented as consistent.

The treatment to date included medications {XX, XX XX, XX, XX, XX (50% relief from the medications)}, XX pump to the unspecified body part, and injection and XX therapy with minimal pain relief.

Per an initial adverse determination letter dated XX, the request for XX XX mg was denied by XX. Rationale: "The Official Disability Guidelines (ODG) for chronic XX therapy require ongoing review and documentation of XX, function, side effects, and appropriate medication use. Objective functional gains from ongoing use are not specified in the submitted documentation. XX is not shown to be medically necessary. Weaning is recommended. Therefore, the requested XX XX mg #XX (name brand only) is not medically necessary."

Per a utilization review decision letter dated XX, the prior denial was upheld by XX. Rationale: "XX therapy has multiple requirements per ODG Pain (updated XX) criteria, including documentation of XX, and improvement of function in addition to lack of side effects, and appropriate medication use. Since the chart provided does not provide enough documentation of all the above criteria, and no peer discussion occurred, XX's medical necessity has not been clearly established. XX of this medication before cessation is recommended.

Therefore, the requested appeal: XX XX mg #XX (name brand only) is not medically necessary or appropriate." Per an addendum, a successful peer-to-peer conversation with XX. The peer mentioned that "the patient has some pain and functional improvement on XX. The patient also has been on XX for XX years and has slowly been XX off the XX / XX XX over the years. However, since the patient has been on XX alone (XX) for XX years without any continued Improvement in pain or function, there is still no sufficient justification for its use, per ODG criteria. Therefore, this non-certification is upheld."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The review centers on the necessity of a prescription of XX XX #XX. This patient has chronic XX pain and has received several different treatment modalities. Notably, an XX XX is in situ. With this therapy, the pharmacological agent is typically infused into the XX space. Use or XX XX may be potentially risky in this situation, since XX may exist between the XX pharmacologic agent and the oral medications, creating a potential XX situation. Two prior utilizations reviews on XX and XX correctly identified the complete lack of any evidence of further benefit of the medication, and recommended XX. The use of chronic XX therapy in excess of XX years also has potential safety issues in the presence of an XX pump. Given the documentation available, the requested service(s) is considered not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines

  Pain Chapter

  CRITERIA FOR USE OF XX

  Therapeutic Trial of XX

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.