I-Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 790-2280
Email: manager@i-resolutions.com

Review Outcome

Description of the service or services in dispute:

Request for XX XX/XX mg, XX XX mg, XX, XX XX mg and XX XX mg.
XX-XX XX / XX XX/XX mg, #XX
XX-XX XX mg, #XX
XX-XX XX / XX XX
XX-XX XX XX mg, #XX
XX-XX XX XX mg, #XX

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

Board Certified Physical Medicine and Rehabilitation and Pain Management

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 had a XX XX. The biomechanics of the injury was not available in the medical records. XX was diagnosed with XX XX of the XX (XX.XX). The handwritten and inadequately scanned medical records were largely illegible.

On XX, XX. XX was seen by XX XX, XX for XX XX pain, rated 4-5/10 and XX XX pain. On examination, the gait was antalgic. Spasms were also noted. Ongoing medications were XX, XX, XX, XX, Vitamin injection, XX and XX. The assessment was XX wounds. The plan was to renew XX and give a prescription for XX XX XX. Per a visit note dated XX by XX. XX, XX. XX presented for a follow-up. The pain was rated 2/10, but was variable during activity. XX had been laid off. XX examination showed good anterior and posterior range of motion (ROM). An antalgic gait was noted. The strength of XX XX extremities, XX XX extremity, and XX XX extremity was 4+/5.

XX XX XX dated XX was 2395 (High) for XX, 387 (High) for XX, and 4685 (High) for XX.

Notice of Independent Review Decision

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The treatment to date included medications (XX, XX XX, XX, XX, XX, and XX) and XX XX XX. XX had XX XX (GSW) on XX to the XX, XX, and XX XX extremity and had XX surgeries, most notable was XX interbody fusion (LIBF) at XX-XX and XX-XX.

Per an initial adverse determination letter dated XX and peer review dated XX, the request for XX, XX, XX, XX and XX was denied by XX. Rationale: "Per the note dated XX, the prescribed medications were renewed. XX. XX had complained of XX XX pain, which was rated at 4-5/10. The symptoms were associated with XX extremity pain. However, the efficacy of the medications was unknown. Based on the provided documentation, the medical necessity of the request was not established. Therefore, the requested service was not medically necessary. However, due to the nature of the medications, weaning could be indicated, if XX. XX was taking the medications."

Per a utilization review decision letter dated XX and peer review dated XX, the prior denial was upheld by XX. Rationale: "(1) XX- XX: Based on the limited documentation provided, the request was not medically necessary. There was no documentation to support the requested medication. The most recent documentation provided was that of XX. There was no documentation of improvement in activities of daily livings (ADLs) nor functionality, or nor documentation of prior XX XX X or Prescription Monitoring Program (PMP). As such, the request was not medically necessary at the time. However, due to the nature of the medication, XX XX would be necessary, if XX. XX was taking the medication. (2) XX – Based on the provided documentation, the request was not medically necessary. There was no documentation of neuropathic or radiculopathy pain. Furthermore, there was no documentation if XX had tried and failed other therapies. As such, the request was not medically necessary at the time. However, due to the nature of the medication, weaning schedule would be necessary, if XX. XX was taking the medication. (3) XX – Based on the provided documentation and Official Disability Guidelines (ODG) guidelines, the request was not medically necessary. Though XX. XX had a history of XX pain, the requested medication was only recommended for short-term use. There was no documentation of the length of time of use of this medication. Per ODG guidelines, "Recommend non-sedating muscle relaxant with caution as XX-time option for short-term (less than XX weeks) treatment of acute XX XX pain, and for the short-term treatment of acute exacerbation in patients with chronic XX XX pain. Therefore, the request was not medically necessary at the time. However, due to the nature of the medication, XX schedule would be necessary, if XX. XX was taking the medication. (4) XX: Based on the documentation provided, the requested service was not medically necessary. There was no documentation of pain being neuropathic in nature. There was no documentation of prior electromyogram or MRI to support the requested medication. Also, there were no documentation if XX. XX had tried or continued conservative therapy. Therefore, the request was not medically necessary at the time. However, due to the nature of the medication, XX schedule would be necessary, if XX. XX was taking the medication. (5) XX: on the documentation provided, the request was not medically necessary. Though XX. XX had a history of XX XX pain, there was no documentation if XX had tried and failed all other medications prior to the requested medication. The guidelines for the requested medication was still under study. Per the ODG Guidelines, these agents would be used to treat neuropathic pain, when XX, XX, or XX could not be used. Therefore, the request was not medically necessary at the time. However, due to the nature of the medication, XX schedule would be necessary, if XX. XX was taking the medication."

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

The records submitted for review would not support the medications in question as reasonable or necessary.

Regarding XX XX/XX, the use of short acting XX can be considered as an option for the treatment of acute to chronic XX pain after failure of XX line options for pain control. There is less evidence supporting the efficacy of XX medications in treating chronic XX or neuropathic 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 XX 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 records also did not include any recent risk assessments or XX XX XX testing for compliance measures as recommended by guidelines for long term use of XX medications. Given these issues which do not meet guideline recommendations, it is this reviewer's opinion that medical necessity is not established and the prior denials remain upheld.

Regarding XX XX and XX XX, these XX can be prescribed to address neuropathic pain. They are recommended to address neuropathic pain by current evidence based guidelines. However, the records did not clearly document the extent of pain relief or functional improvement with the ongoing use of this medication. Without additional clinical information to support the ongoing use of this medication, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld.

Regarding XX XX, this XX XX is routinely prescribed to address neuropathic pain as well as XX and XX. It is recommended to address neuropathic pain by current evidence based guidelines. However, the records did not clearly document the extent of pain relief or functional improvement with the ongoing use of this medication. There were no other clear indications for the ongoing use of XX. Without additional clinical information to support the ongoing use of this medication, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld.

Regarding XX, muscle relaxers are not recommended for long term use to treat chronic XX pain. Muscle relaxants such as XX can be used to address acute flares of XX pain in chronic cases in the short term. There was no indication from the records that the claimant had any recent flares of XX pain to support the use of XX in the short term. As long term use of XX would not be recommended, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld.

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 XX Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards

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- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☐ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ 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.