Date notice sent to all parties: 3/12/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of XX XXmg XX #XX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in Anesthesiology.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of XX XXmg XX #XX.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XX year old XX with a date of injury of XX. The mechanism of injury was this claimant was XX a XX XX in XX XX while XX XX XX. XX XX XX into the claimant's XX XX injuring XX XX XX and XX. XX diagnosis includes pain in XX upper XX, complex regional pain syndrome. The treatment history includes medications, rest, heat/ice, restrictions, XX XX block, XX epidural steroid injection XX, restrictions, 70% improvement from ESI, also doing well on XX XX therapy reporting more than 70% improvement of XX overall pain complaints. Per office visit note of XX, this claimant continues to do well with the XX XX therapy elevating more than 70-80% of XX ongoing complaints including burning, swelling and CRPS of the XX XX extremity. The request is for XX XXmg XX #XX.

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

Per evidence-based guidelines, and the records submitted, this request is non-certified. Per ODG, XX is not recommended for XX and XX secondary to chronic XX use. Rather, it is recommended for acute use for FDA approved indication. The claimant is receiving XX for XX chronic pain, but XX is not recommended for XX associated with this use of XX. Therefore, this request is not medically necessary.

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition
XX

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)**