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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Pain Medicine

REVIEW OUTCOME:

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

☒ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☐ Upheld	Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who sustained an injury on X. The biomechanics of the injury were not included in the records. The diagnoses included other chronic pain, displacement of thoracic intervertebral disc without myelopathy, pain in thoracic spine, and other intervertebral disc displacement in thoracic region. Per the prior review, X was seen by X, MD and Dr. X Orr on X, there was documentation of X being followed for X. X had been stable on X. The last pain contract was dated X and X stated X was getting X improvement from X. The X was X on X last pain contract which was no risk of opioid misuse or abuse. At the time of visit, X continued to be stable on the medications with no side effects. However, X was having increasing thoracic pain due to weather changes. X had tried X. The pain level was X quite increased from X last pain level at X in X last visit on X. The physical exam revealed X. X was tender in the thoracic spine in the paraspinous area at X. The remainder of the exam was unremarkable. Per the prior review, treatment to date included medication X. Per utilization review by X MD on X, the request for X was non-certified. Rationale: “Per ODG guidelines, "X is recommended as a first- or second-line treatment when Screening and monitoring is planned to assess for abuse, diversion, efficacy, misuse, and safety (eg, checking state PDMP data, urine toxicology testing). Per the record, the claimant has been stable on X." However, there was no recent UDS attached to verify compliance on this case. As such, the requested X is not medically necessary. “Per utilization review by X, MD on X, the request for X was non-certified. Rationale: “Per X, "Both function and pain treatment goals should be established (X) before an opioid trial of X to X weeks is attempted. Before initiating opioids, there should be plans for discontinuation in the event the goals are not met (X). Opioids should only be continued beyond the opioids trial period if both goals are met and these outweigh risks to patient safety (X). Assessment of function and pain at least monthly in the first X months of treatment and then quarterly should be documented. There should be at least X" In this case, there is insufficient documented evidence of specific functional

gains to justify the long-term use of opioids. Furthermore, prior review noted a lack of urine drug testing, and although current records say that urine drug test has been done before, there is no record of urine drug test dates or results. Therefore, the request for X is not medically necessary." Thoroughly reviewed supplied documentation including peer reviews. Patient reports pain relief with X. Continued use indicated given noted pain relief and patient even has a pain contract. X is a schedule X. UDS may be attempted to check for opioid misuse or other drug abuse in the future but not absolutely required as provider checking X. X requested is indicated. X is medically necessary and certified

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

Thoroughly reviewed supplied documentation including peer reviews. Patient reports pain relief with X. Continued use indicated given noted pain relief and patient even has a pain contract. X is a X. UDS may be attempted to check for opioid misuse or other drug abuse in the future but not absolutetly required as provider checking X. X requested is indicated. X is medically necessary and certified

Overturned

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

☐ TMF SCREENING CRITERIA MANUAL