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# *Notice of Independent Review Decision*
## *Amendment X*
## *Amendment X*

**IRO REVIEWER REPORT**

**Date:** X; Amendment X ; Amendment X

**IRO CASE #:**

**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:** X

**REVIEW OUTCOME:**

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

☐ Overturned Disagree

☐ Partially Overtuned Agree in part/Disagree in part

☒ Upheld Agree

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:** · X

**PATIENT CLINICAL HISTORY [SUMMARY]:** X who was injured on X. X was at X. X knocked X contact out and also X. X put X. X sustained a X. The diagnosis was chronic migraine without aura and chronic migraine without aura, intractable with status migrainosus, migrainous vertigo, and vertigo. On X, X was seen by X, MD for a follow-up visit for chronic migraine. X felt that X was getting worse. At that time, X was having almost every day. It took X months to get X approved. On X, X had a little "X"- witnessed by colleague during which X was X. X repealed "we need to call 911". X laid down, then vomited. X had headache (HA). The day prior to that visit, X ", after conference X. X was getting X. The X made X. X had removed X. X noticed some improvement in X. X was taking X. They were trying to wean it off. A X was X. On examination, X blood pressure was 120/60 mmHg, weight was 244 pounds and BMI was 41.9 kg/m2. Physical examination revealed X appeared in X. The X was full. X were X. X face moved symmetrically. X moved all extremities equally without focal weakness. X was administered to X. X were prescribed. Treatment to date included X. Per a peer review report dated X by X, MD, the request for X was denied. Rationale: "Although the initial reviewer opined that request was shown to be medically necessary, the records available at this time do not clearly show that the frequency of the claimants migraine headaches was X. The total number of headache days per month at present is also not specified in the records provided for review. Prior to the initial treatment with X the number of headaches days is documented as "about X migraine days/ mo." Based on the clinical information available, the request for X is not shown to be supported by the ODG. Therefore, the X is not medically necessary." Per a peer review dated X by X, MD, the request for X was denied. Rationale for X: "The ODG does not address the requested X. The manufacturer

recommends initiation of this medication only X. There is no mention of a X prior to the prescription for this medication. As such, the request is not supported. Therefore, X is not medically necessary." Rationale for X: "The records provided indicate that the claimant has previously utilized X as evidenced by a X prescription date but provide no information regarding the clinical response. Consequently, the request for continued use of X is not shown to be supported by the ODG nor otherwise medically necessary. Rationale For X: "The records provided indicate that the claimant has been chronically prescribed the X and at a prior request from X was certified with modification to a quantity of X with a refill to accommodate a wean. The request as prescribed is inconsistent with the weaning efforts documented as intended in the X peer review report. As this medication is not recommended for chronic use and there is no objective evidence of clinical benefits derived from prior use, the request is not shown to be supported by the ODG nor otherwise medically necessary. This medication should not be stopped abruptly and should be weaned. Therefore, X is not medically necessary. However, due to the nature of this drug, weaning is recommended." Per utilization review dated X, request for X was denied. Per a peer review report dated X by X, MD, the appeal request for X was denied. Rationale for X: "In this case, X has been tried before with no clinical response. The records provided indicate that the claimant has previously used X on X prescription. There is no information regarding the clinical response. The request for continued use of X is not shown to be supported by the ODG nor otherwise medically necessary. Therefore, the X is not medically necessary. However, due to the nature of the medication, weaning is recommended." Rationale For X: "In this case, the claimant has been chronically prescribed the requested X. However, X is not indicated for chronic use. The prior request from X was certified with modification to a quantity of X with a refill to accommodate a wean. There is no objective evidence of clinical benefits derived from prior use. The

request is not supported by the guidelines. Therefore, the X is not medically necessary. However, due to the nature of the medication, weaning is recommended." Per a utilization review dated X, an appeal request for X was upheld. Official Disability Guidelines supports X. The notes comment that despite several medication for migraine X continued to have X headache days a month. On X reported having a little "X"- witnessed by colleagues. The claimant is receiving X; however, there is no documentations about whether X has an appropriate beneficial response to support continuation of X. There is lack of documentation of first line medications. X is not a proven antiepileptic medication to prevent migraine and there is poor documentation of a X diagnosis. Based on review of the records and guidelines, the request for X is not medically necessary and X Official Disability Guidelines supports limited use of X. The records indicate the claimant was taking X. The records indicate the claimant has been chronically prescribed X and on X X was certified with modification to a quantity of X with a refill to allow weaning. There is lack of documentation regarding any weaning effort, the X condition, number of episodes and response to medications to support continued use in excess of guideline recommendations. Based on review of the records and guidelines, the request for X is not medically necessary and non certified

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

Official Disability Guidelines supports X. The notes comment that despite several medication for migraine X continued to have X headache days a month. On X reported having a little "X"- witnessed by colleagues. The claimant is receiving X; however, there is no documentations about whether X has an appropriate beneficial response to support

continuation of X. There is lack of documentation of first line medications. X is not a proven antiepileptic medication to prevent migraine and there is poor documentation of a X diagnosis. Based on review of the records and guidelines, the request for X is not medically necessary and non certified X Official Disability Guidelines supports limited use of X. The records indicate the claimant was taking X. The records indicate the claimant has been chronically prescribed X and on X, X was certified with modification to a quantity of X with a refill to allow weaning. There is lack of documentation regarding any weaning effort, the anxiety condition, number of episodes and response to medications to support continued use in excess of guideline recommendations. Based on review of the records and guidelines, the request for X is not medically necessary and non certified
Upheld

**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**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **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**

☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**