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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: X

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 was injured on X. While employed for X, X was X. The diagnoses were other spondylosis, cervical region (M47.892); cervicalgia (M54.2); other cervical disc displacement, mid-cervical region, unspecified level (M50.220); post laminectomy syndrome, not elsewhere classified (M96.1); other chronic pain (G89.29); vascular headache, not elsewhere classified (G44.1); radiculopathy in the lumbar (lower back) region (M54.16); other muscle spasm (M62.838); myalgia, unspecified site (M79.10); long-term (current) use of opiate analgesic (Z79.891); headache, unspecified (R51.9); body mass index (BMI) 38.0-38.9, adult (Z68.38); and essential (primary) hypertension (I10).X presented to see X, MD on X for a follow-up and medication refill. X complained of cervical, thoracic, and lumbar spine pain. X did report radiating pain going down X right arm and bilateral leg. X also suffered for severe headaches due to neck injury. X pain had been onset since X due to a work injury X had. The pain was described as aching, stabbing, throbbing, and tingling. It worsened when X was standing, walking, with head rotation, sitting for long periods of time, and other daily activities. X did have a history of having X. X stated X had been having severe neck pain and having decreased range of motion. X admitted to stiffness and knots on X neck. X stated that since the prior month, X had been having pain on X right buttock that went down into X right leg when driving or walking. X also reported of needles, pins and numbness over the lateral aspect of X leg that went down to X knee. X stated X had been having to take over-the-counter pain relievers, which did not do much for X pain. X reported that when X took X as directed, it provided X with 85% relief, and X was able to function with X daily activities. On examination, X blood pressure was 126/70 mmHg, oxygen saturation was 98%, and BMI was 33.7 kg/m2. The pain was rated at X. X was in moderate distress. X had limited ambulation and ambulated with a cane. Vision acuity was impaired (wore glasses). The neck was tender, and there was pain with motion. On

musculoskeletal examination, X was aX. X and X was noted of the joints, bones, and muscles. X was X(X), and X was X. On cervical spine examination, there was X. X was noted. On thoracic spine examination, there were X. X was noted. The assessment included chronic pain, lumbar radiculopathy, myalgia / myositis, post-laminectomy syndrome, spasm, cervical radiculopathy, pain in thoracic spine, headaches, essential hypertension, long-term current use of opiate analgesic drug, and body mass index 30+, obesity. The dose of X was increased to X. X was refilled. X was increased to X, and X. An MRI of the lumbar spine was ordered. Treatment to date included X.Per a utilization review adverse determination letter and peer review dated X by X MD, the request for X was denied. Rationale for denial of X: “Per ODG, “Before initiating therapy, the patient should set goals (including for pain and function), and the X. Realistic expectations and limitations of X.” In addition, “Ongoing assessment should continue to include pain and function outcomes, as well as progress towards treatment goals. This should be documented. A LACK OF CLINICALLY MEANINGFUL IMPROVEMENT IN FUNCTION IS A REASON FOR DISCONTINUING X.” Objective functional gains from ongoing use and treatment goals are not specified in the records in meaningful detail. X is not shown to be medically necessary. Therefore, the X is non-certified.”” Rationale for denial of X: Per ODG, “X may be indicated when ALL of the following are present (1) (2): Age X years or older…Tension headache (refractory), and ALL of the following: Patient has failed to respond or has contraindications to ALL of the following: X…Prescription is for X-day supply or less.” In this case, the prescription is for much more than a X-day supply, and X are noted. The request is not medically necessary. Therefore, the retrospective request for X is non-certified.”” Rationale for denial of X: Per ODG, “X may be indicated for ALL of the following…Age X years or older…Condition is 1 or more of the following: Muscle spasticity in multiple sclerosis…Muscle spasticity in spinal cord injury or diseases…Patient not concurrently X…Patient does not perform critical or hazardous job duties

such as commercial driving, operating heavy machinery, or public safety." In this case, there is a record of X. X is not shown to be medically necessary. Therefore, the retrospective request for X is non-certified."Per a reconsideration review adverse determination letter dated X and peer review dated X, the prior denial was upheld by X, MD. Rationale for denial of X: "Official Disability Guidelines discusses the X. X are not generally recommended for treatment of non-malignant musculoskeletal pain. The medical records at this time do not clearly document specific objective functional benefits from X. Lab reports from X are not available Overall a rationale or indication for X. The request is not medically necessary and should be denied." Rationale for denial of X: "Official Disability Guidelines discusses X. The guidelines do not recommend this X. The request is not medically necessary and should be denied." Rationale for denial of X: "Official Disability Guidelines discusses X. This medication acts on the X. The medical record in this case does not document the presence of spasticity nor an alternative indication for X. Without further clarification, the request is not medically necessary and should be denied."Thoroughly reviewed provided records including peer reviews.Unclear based on provided documentation if provider is X. Further, X not indicated for long term use or without reason why X could be used alone. Last, patient without documented spasticity thus X not indicated. X are not medically necessary and non certified

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

Thoroughly reviewed provided records including peer reviews.Unclear based on provided documentation if provider is following X is effectively treating patient's pain. Further, X not indicated for long term use or without reason why X could be used alone. Last, patient without documented spasticity thus X not indicated. X, are 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

☐ 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