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Notice of Independent Review Decision

Original X

Amendment X

Amendment X

Amendment X

IRO REVIEWER REPORT

Date: Original X; Amendment X; Amendment X; Amendment 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. X had a history of X from a work-related injury on X. The biomechanics of the injury were not available in the provided records. The diagnoses were migraine unspecified not intractable without status migrainosus, posttraumatic headache with migraine features, occipital neuralgia, myofascial pain syndrome of the cervical spine, and depression / anxiety with mild neurocognitive disorder. X had a telemedicine consultation with X, MD on X for a follow-up. X reported X migraine had worsened since X ran out of X. Though X prescription had been approved through X, X found out X co-pay amount was cost prohibitive. Therefore, X had decided to try to get X prescription through the workers' compensation case. A letter of medical necessity had been submitted two weeks prior. X was hoping to resume X for migraine prophylaxis as X was experiencing a significant improvement in X overall migraine patterns while taking that X. X remained on X and as needed use of X and did not need prescription renewals. X reported no changes to X other medications, which had been prescribed by X psychiatrist. These medications included X. X wanted to stay on a six-month follow-up schedule. The assessment included posttraumatic headache, with migraine features, in a chronic pattern, partially improved on X with X and X, which worsened since running out of X. X had occipital neuralgia bilaterally, contributing to X frequent headache and migraine as a trigger, improved in the past after treatment with X and with X, but

recurrent, treated symptomatically with X. X had a telemedicine follow-up with Dr. X on X. X reported X was doing “okay” on X. X had found that X worked better for X but that was no longer covered by X insurance. X wanted to renew the X prescription. X also remained on X. X wanted to renew that for X usual three-month supply. X reported no changes to X other medications, which included X. X maintained follow-up with X psychiatrist. X was noted to have a X during the telemedicine visit. X reported X symptoms had been present chronically but it did become worse at times. X related it to X. Treatment to date included medications X. Per a letter dated X, the request for X. X did not meet established standards of medical necessity. The request was non-certified. Per a peer review report dated X by X, MD, the request for X. X was noncertified. Rationale: “ODG regarding the request for X“X may be indicated when ALL of the following are present: Migraine headache, as indicated by 1 or more of the following: Migraine headache X needed for episodic migraine (defined as migraine frequency of 4 to 14 days per month for 3 or more months. Migraine headache treatment in patient with history of acute migraine with or without aura and contraindication, failure, or intolerance to 2 or more X.” In this case, the claimant reportedly sustained post-traumatic headache with migraine features from a X. A prior peer review denied the request for X due to there is no documentation of no documentation of failed trails of other medications. The peer review also states, of note, the claimant had occipital neuralgia, as well as myofascial pain syndrome stemming from X cervical spine that are contributing to X headaches. The letter of medical necessity that X has offered the claimant some reduction in X migraine frequency and X is noted to have X. However, there is no documentation X. As such, medical necessity is not established. Therefore, the request for X is non certified. “Per an appeal peer review report documented for referral date X by X, MD, the request for X was not medically necessary. Rationale: “The Official Disability Guidelines (ODG) by X, “X may be indicated when ALL of the following are present:

(1): X(2):X. (3)X(4)(5).”Per the X denial: “A prior peer review denied the request for X due to there is no documentation of no documentation of failed trials of other medications. The peer review also states, of note, the claimant has occipital neuralgia, as well as myofascial pain syndrome stemming from X cervical spine that are contributing to X headaches. The letter of medical necessity states that X has offered the claimant some reduction in X migraine frequency and X is noted to have failed multiple other X. However, there is no documentation X. Within the documentation provided for review, the claimant has migraines. The claimant has failed multiple other medications. However, there is no clear documentation that the claimant has migraine headache frequency of 4 to 14 days a month for three or more months to support this medication. There is also no clear documentation that the claimant has X. In addition, the provider notes that prior use of X has decreased frequency of headaches. However, there is no objective documentation of efficacy to support continue to use. In addition, there is no documentation to support X at one time. As such, medical necessity is not established. Therefore, the request for X On Appeal, is APPEAL X. X is noncertified. “Per a letter dated X, the appeal for X was upheld. Thoroughly reviewed provided records including peer reviews. Per the cited ODG criteria that reviewers utilized, patient meets criteria for use of X. Not only has X found success with X and X, but X has also had trials with X without success. X has also had many other treatments over the years. Given relief found with requested X along with extensive treatment history, while meeting ODG criteria, request for X is indicated.X . 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 provided records including peer reviews. Per the cited ODG criteria that reviewers utilized, patient meets criteria for use

of X. Not only has X found success with X, but X has also had trials with multiple X without success. X has also had many other treatments over the years. Given relief found with requested X along with extensive treatment history, while meeting ODG criteria, request for X is indicated. X. 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