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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

Date: 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

Pure Resolutions LLC

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured at work on X. The mechanism of injury was not included in the provided medical records. The diagnoses were chronic thoracic pain secondary to calcified X disc herniation and X disc displacement.

On X, X was evaluated by X, FNP / X, MD for a follow-up of chronic thoracic pain. X was being followed x. X was injured on X. X had been stable on X. X had been taking X. X got X improvement from X X. However, the insurance carrier was denying the X. Then they switched X to X. They appealed the X. X reported X believed that at the time they would pay for the X, so X would like to go back. At the time of visit, X continued to have chronic thoracic pain. X took X and X. X was very stable. X sometimes did require an occasionally X. X was X. At the time, X rated upper back pain as X. Neurological examination revealed X. Straight leg raising (SLR) test was X. Motor strength remained X. Hoffman's reflex, clonus, and brachioradialis reflex remained X. The plan was to continue X and X.

Treatment to date included medications X.

Per the utilization review dated X by X, MD, the request for X was denied. Rationale: "X used in the treatment of acute and chronic pain.

The Official Disability Guidelines recommend X. In this case, the claimant was diagnosed with a displacement of the thoracic intervertebral disc without myelopathy, pain in the thoracic spine, and other Intervertebral disc displacements, thoracic region. According to the Follow-up Visit by X, M.D., on X, there was documentation of chronic thoracic pain, MED is X. Based on the available documentation and medical treatment guidelines, medical necessity could not be established. There was no documentation available dated in the last X months. Per the available documentation, the claimant was previously on X, but there was no documentation of sustained benefit with X. Since this has Texas jurisdiction and a peer discussion did not occur, a modification for warning is not possible. Therefore, the request for X is not medically necessary."

On X, Dr. X, wrote letter of appeal for denial of the request for X, stated that "This is a letter of appeal on patient, X. X is currently under my care for X. X was injured on X. X has been quite stable on X. X gets at least X improvement from X However, X insurance carrier has denied the X. We did switch X to X. We would therefore like to appeal this denial. Patient meets all criteria for someone who needs chronic pain medications. X is stable. X has had no side effects. X has been on it for many years, which allows X to continue activities of daily living."

Per the utilization review on X by X, MD, the request for X was denied. Rationale: "This medication is an X. ODG guidelines for X. Per ODG, "Before initiating therapy, the patient should set goals (including for pain and function), and the continued use of X. Realistic expectations and limitations of X should be discussed," 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." In this case, objective functional gains from prior use of X. Therefore, the request for an Appeal for X is not medically necessary."

The available records noted the claimant's ongoing chronic pain in the mid to lower back. The claimant had used X. The claimant did not improve with other options for pain control such as X. The claimant denied any side effects with X. Given the noted efficacy of X for chronic pain without side effects, this medication should be continued. The claimant has a low MED dose without any notable risk factors. Therefore, it is this reviewer's opinion that medical necessity is established for the requested X and the prior denials are overturned. X is medically necessary and certified

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

The available records noted the claimant's ongoing chronic pain in the mid to lower back. The claimant had used X. The claimant did not improve with other options for pain control such as X. The claimant denied any side effects with X. Given the noted efficacy of X. The claimant has a low MED dose without any notable risk factors. Therefore, it is this reviewer's opinion that medical necessity is established for the requested X is medically necessary and certified

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Overturned

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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

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

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

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☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE