I-Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 IR
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 790-2280
Email: @i-resolutions.com

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services

in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • x

PATIENT CLINICAL HISTORY [SUMMARY]: x who was injured on x. Please note, no records were available for review other than 2 utilization reviews. Per a utilization review adverse determination letter dated x, the request for x, was denied by x, DO. Rationale: "The Official Disability Guidelines state that x may be indicated as migraine prophylaxis for age x years or older, without concomitant use of alcohol or sedating medications and no critical or hazardous job duties. In this case, the claimant reported neck and head pain. They have a history of headaches which were in the back of the eyes and radiate to the temple with light sensitivity. The claimant also reported significant relief of neck pain and headaches from x. The records indicate that the claimant was taking x. However, there is no documentation of pain relief and functional benefit from taking this medication. In addition, there is insufficient documentation in the records submitted of the claimant's current headache symptoms and physical findings. As such, the request for x is non-certified. The Official Disability Guidelines state that x. In this case, the claimant reported neck and head pain. They have a history of headaches which were in the back of the eyes and radiate to the temple with light sensitivity. The claimant also reported significant relief of neck pain and headaches from x. The records indicate that the claimant was taking x. However, there is no documentation of pain relief and functional benefit from taking this medication. In addition, there is insufficient documentation in the records submitted of the claimant's current headache symptoms and physical findings. As such, the request for x is non-certified." Per a reconsideration review adverse determination letter dated x, the appeal request for x, was denied by x, MD. Rationale: "The Official Disability Guidelines supports the usage of x

for migraine headache prophylaxis without the use of other sedating medications or hazardous duty. This claimant has continued migraine headaches and a diagnosis of traumatic brain injury and postconcussive syndrome. Physical examination reveals tenderness and decreased range of motion of the cervical spine and positive cervical facet loading. However, this claimant has had previous usage of x. Previous reviews did not certify this request due to lack of documented efficacy with previous use. Notes from the requesting provider dated x do not address this concern. Understanding this claimant's migraine history and lack of efficacy with other medications, and without information regarding its previous efficacy, this request for x is noncertified. Regarding x, guidelines support the use of this medication as a first- or second-line treatment option also for migraine headache prophylaxis. There has not been significant benefit with x. There are continued complaints of migraine headaches. A previous review did not certify this request as the efficacy of previous usage of x was not stated. Notes from the requesting provider dated x do not address this concern. This request for x x is noncertified. Thoroughly reviewed provided records including provider notes and peer reviews. Patient with strong migraine history with some relief of pain noted by combination of x. Given success from prior use, continued use is warranted based on guidelines cited by peer reviews. x are 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 provider notes and peer reviews.

Patient with strong migraine history with some relief of pain noted by

combination of x. Given success from prior use, continued use is warranted based on guidelines cited by peer reviews. x are 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**
- ☒ **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)**