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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 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:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. X.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case concerns a X who has requested authorization and coverage for X. The Carrier denied this request on the basis that these services are not medically necessary for treatment of the member's condition.

On X the member's treating physician wrote a letter in support of this request. It indicated that the member is being treated for X. It noted that the member was injured on X. It indicated that the member has been quite stable on X. It noted that the member gets at least X percent (%) improvement from X and X from X. It indicated that however, the member's insurance carrier has denied the X. It noted that the provider did switch X to X. It indicated that the provider would therefore like to appeal this denial. It noted that the member meets all criteria for someone who needs chronic pain medications. It indicated that the member is stable and has had no side effects. It noted that the member has been on it for many years, which allows X to continue activities of daily living.

The Carrier has indicated that these services are not medically necessary for treatment of the member's condition. The Carrier noted that per Official Disability Guidelines (ODG), "Before X. Realistic expectations and limitations of X". The Carrier indicated that in addition, "Ongoing assessment should continue to include pain and function outcomes, as well as progress towards treatment goals". The Carrier noted this should be documented. The Carrier indicated that in this case, the objective functional gains from ongoing use and treatment goals are not specified in the records in meaningful detail. The Carrier noted that X. The Carrier explained that therefore, the Appeal request for X is not medically necessary.

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

The Maximus physician consultant indicated that regarding the request for X. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. The CDC recommends a 3-item (PEG) Assessment Scale. This includes a pain assessment, a measure of pain interference with enjoyment of life, and a measure of pain interference with

general activity (all using a scale of 0-10).” The Maximus physician consultant noted that the guidelines go on to state "ongoing assessment should continue to include pain and function outcomes, as well as progress towards treatment goals. This should be documented. X. A X improvement in pain and function is considered clinically meaningful. Again, the CDC recommends the 3-item (PEG) Assessment Scale (described above).” The Maximus physician consultant indicated that the guidelines note that “Chronic low back pain: Not recommended as a X. Recommended as a second-to third-line choice for paint treatment in patients who have X.”

The Maximus physician consultant explained that within the documentation available for review, there is no currently noted X. The Maximus physician consultant noted that moreover, no currently noted objective functional improvement is noted in the member with X.

The Maximus physician consultant indicated the requested X is not medically necessary. The Maximus physician consultant explained that this decision addresses the medical necessity of X. The Maximus physician consultant explained that this medical necessity decision should X. The Maximus physician consultant noted that the treating physician and the member are advised to consult ODG recommendations, and if

necessary, other relevant guidelines, regarding the most appropriate method for X.

Therefore, the requested Xis not medically necessary for the treatment of the member's condition.

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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

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

OPIOIDS FOR PAIN, CRITERIA FOR USE; OPIOIDS FOR CHRONIC PAIN

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

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

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE**

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