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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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X had a work episode where X. The diagnosis was lumbar disc disease with radiculopathy (X); overweight (X); long-term use of drug (X); osteophyte of spine (X); other spondylosis with radiculopathy, lumbar region (X); postlaminectomy syndrome of lumbar region (X); facet arthropathy, cervical (X); sacroiliac joint pain (X); tobacco non-user (X); intervertebral disc disorders with radiculopathy, lumbosacral region (X); and spinal stenosis, lumbar region (X).

On X, X was evaluated by X, MD via telemedicine. X reported X. X was X. The first X was in X, and the second one was in X. X had X. X stated X right side bothered X more than X left. X had pain to X foot with paresthesias, numbness, and weakness. MRI of the cervical spine in X showed that X X. X had this X. At X, X had a X. MRI of the lumbar spine in X showed X had some X. X had X. There was some X. At X. At X, X had X. Review made by Workers' Compensation physician on X stated that the X was not related to X initial injury. ·X had also had a cervical MRI that was done at X. Cervical spine x-rays done at X in X showed some X. X was advised by the neurosurgery PA, X that X should have X. Left arm numbness started about X. X-rays of the lumbar spine from X, showed that X had X. There was X. X did have X. The X. X-rays of the cervical spine in X, showed X had X. X had X above X scar in X, but they were not effective. However, X. x done in X showed a score of X which was low risk. COMM score from X revealed a score of X, which was low risk. For urine drug testing (UDT), X was low risk as of X. X was weaned off X in X, lowered to X and then in X, X was X. Physical examination was not performed that day because the visit was virtual using real-time audio and video. Dr. X noted, X was looking forward to X. This would be done at X. X was still not able to walk for more than X minutes and did get some episodes of numbness

down X right leg. The pain as X described it and Dr. X reviewed with X today is still the piercing throbbing pain which felt like needles down X right leg all the way down to X ankle. X was at the same level for similar right radicular pain in X, and X had over X year X relief level with that X. The X report was checked and it was okay. X continued to benefit from X. Dr. X would plan to see X again in about X days. Per an addendum dated X, Dr. X noted X would renew X medications electronically that day. The X was checked and was okay. Per an addendum dated X, Dr. X noted, the Workers' Compensation carrier for X had decided to, at the time, not cover X medications for pain. Dr. X was trying to arrange a peer-to-peer discussion with them. At that time, X was completely out of medications and called the office that day stating that X was in a lot of pain. Dr. X will, therefore, send X, in the meantime, X. Hopefully, Dr. X would get to speak to X Worker's Compensation carrier. Per an addendum dated X, Dr. X noted X would renew X medications electronically that day. The X report was checked, and it was okay. Dr. X would have X come for random urine testing to make sure X was taking X specific medications. Per an addendum dated X, Dr. X wrote, "I had a scheduled peer-to-peer call last week on X but I was working at the hospital and so this was rescheduled until today which is X. X days after the scheduled peer-to-peer call on X the Worker's Compensation service issued an adverse determination on X. This is despite my peer-to-peer call being scheduled for today which is X. In the adverse determination multiple factual errors are present. Such as the statement that X has not had urine drug screening since X. This is not correct. X is only allowed to have it twice per year but did have drug screening on X and is currently scheduled to have another drug screen in the X. X does in fact have a *X* and it was incorrectly stated that X. It was also incorrectly stated that when I spoke to Worker's Compensation on X it was indicated that this would be X last X. That was not at all correct. This was merely to get X next X improved until I could set up a peer-to-peer conversation. It is now X and the scheduled peer to peer with Worker's Compensation scheduled for X has not taken place. They have not called me. I am assuming that they have decided to issue the adverse determination rather than do the peer-to-peer. I do not feel that this is in good faith on their part. I will advise the patient to appeal since they have not followed

the proper process. On X, X visited Dr. X for follow-up. On examination, X was alert and oriented and was a good historian. X walked rather stiffly and was in obvious moderate distress in terms of X low back pain. Dr. X noted X had seen X that day in person. X had good results from X. This was done for X. X estimated that once again, X was getting about X pain relief from this X, and it had now been about X months, so this was very successful. However, X did continue to have a lot of low back pain due to X. X had been stable on X ongoing X.

This had kept X functional. Dr. X believed it was medically necessary that X continue this medication. They had been able to steadily wean medication and referred X to get off this medication suddenly, X had not realistic. Unfortunately, Dr. X was sent a notice dated X from X Workers' Compensation carrier stating that X medications were no longer medically necessary. Dr. X had scheduled a peer-to-peer conference with them for X, and they did call Dr. X but Dr. X was still X. This was then rescheduled with them, so that Dr. X would have a peer-to-peer meeting on X. They however did not call Dr. X. The Workers' Compensation carrier however had X days earlier decided that since Dr. X did not talk to X on X, they would therefore issue this adverse recommendation. They did not go to the peer-to-peer meeting that Dr. X had scheduled with them for X. Dr. X discussed this with X along with a lot X. There were many factual errors and Dr. X did not think X should be weaned off X medication suddenly. Dr. X did advise X to file an appeal with the Workers' Compensation carrier. X stated X would do so and submit in the next X days. Dr. X was very concerned because X did have a valid Workers' Compensation claim and X had been stable on the ongoing medication that Dr. X believed was medically necessary but Dr. X did not think X Workers' Compensation carrier was acting in good faith by not showing up for a scheduled peer-to-peer but then issuing an adverse determination a few days after Dr. X was not able to speak to them. Since X was being denied X, Dr. X would have to give X some X over the next week until X could file X appeal. Hopefully, this would trigger processes whereby X could continue to receive X medication. The X report was checked and it was okay. Pain score that day was about X or X out of X. X was however staying functional and the ongoing medication would run out that day. X

would be seen again as needed, probably get X in the office in about X days.

A urine drug screen (UDS) dated X, X. The study revealed X. Medications prescribed included X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Principal Reason(s) for the Determination: “Full certification is not supported as the requests in their entirety do not meet guidelines. See detailed explanation below.” “Utilization review determination report dated X indicates that prescription medication X was not medically necessary X. Utilization review determination report dated X notes that X was medically necessary since the claimant was in a lot of pain without this medication and was unable to function. Prescription form dated X notes the prescription for X.” “ODG notes that X may be indicated for chronic non-cancer pain and all of the following such as screening and monitoring is planned to assess for abuse, diversion, efficacy, misuse, and safety, patient is determined to be X, prescriber certifies presence in the medical record of the agreement between patient and prescriber, and active treatment plan is in place as indicated by X or more of the following such as X an X has not been effective for pain relief or improved function after a trial of X weeks, In this case, utilization review determination report dated X notes that X was medically necessary since the claimant was in a lot of pain without this medication and was unable to function, There is no documentation of quantifiable improvement in pain and objective functional benefit specifically associated with the use of this medication. Additionally, the claimant is prescribed with X and there is X , Given these factors, the request for X is not medically necessary, Based on the prior reviews, the claimant should already have been completely weaned from this medication, However, it is the provider's responsibility to use X own judgment and/or protocol, based on the individual needs of the claimant, which may or may not include additional weaning through the provider.”

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Per a reconsideration review adverse determination letter dated X, the appeal request X, was denied by X, MD. Rationale: “Principal Reason(s) for the Determination: Certification is not supported as the request does not meet guidelines, See detailed explanation below.” “Prior treatment has included X. X was signed on X. Laboratory report dated X reveals positive results for X. Visit note dated X indicates that the claimant has pain to the foot with paresthesia, numbness, and weakness. X completed in X had a score of X which is low risk. Current opioid Misuse Measure score in X had a score of X which is low risk. The claimant weaned off X, the claimant was weaned to X, Examination shows that the claimant walked rather stiffly and is in obvious moderate distress in low back pain. The claimant is stable on current X. The claimant notes that this has kept the claimant functional. The provider believes that it is medically necessary that the claimant continue this medication. The provider has been able to steadily wean medication and referred the claimant to get off this medication. The claimant notes that as X is being denied, the provider recommends X until the claimant can file an appeal. The X was checked, and it was okay. The pain score is about X or X. The claimant is staying functional and current medication runs out at this time. The claimant was assessed for X. The provider recommends X. Initial utilization review report dated X indicates that X was not medically necessary as there is no documentation of objective functional benefit associated with the prior use of the medication. In addition, the submitted report notes a plan to start X and there is no indication to support X.” “ODG states that X may be a first-line or second-line option, It is indicated if screening and monitoring is planned to assess for abuse, diversion, efficacy, misuse, and safety (eg, checking stale PDMP data, urine toxicology testing), Patient is determined to be a suitable candidate for X (X), Prescriber certifies presence in medical record of agreement between patient and prescriber addressing issues of diversion, doctor/pharmacy shopping, prescription management, and use of other substances. Patient had improved function or pain with a previous prescription of medication, Patient has been re-evaluated by prescriber since a previous prescription for medication was issued. Urine toxicology scheduled testing for adherence performed. Prescription is for X.

Pain requires daily around-the-clock long-term treatment. Pain significant enough to X. Patient is currently X. Patient was previously treated with X. In this case, initial utilization review report dated X indicates that X was not medically necessary as there is no documentation of objective functional benefit associated with the prior use of the medication and the submitted report notes a plan to start X. There is no indication to X. Documentation does not provide measurable objective functional benefit associated with medication use. There is also no documentation of attempt at weaning and tapering. Therefore, this request is not medically necessary."

The claimant had been followed for X. The claimant had been prescribed X. The claimant had a consistent urine drug screen in X. At the X evaluation, the claimant reported moderate levels of distress. No pain scores were detailed. The claimant's prescribed X. X can be considered an X. The current records did not detail the specific effectiveness of X for the claimant's chronic pain in terms of pain reduction or functional improvement. Therefore, it is this reviewer's opinion that medical necessity for the service in dispute: X is not medically necessary and the prior denials are upheld. X is not medically necessary and non-certified

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

The claimant had been followed for X. The claimant had been prescribed X. The claimant had a consistent urine drug screen in X. At the X evaluation, the claimant reported moderate levels of distress. No pain scores were detailed. The claimant's X can be considered an X. The current records did not detail the specific effectiveness of X. Therefore, it is this reviewer's opinion that medical necessity for the service in dispute: X is not medically necessary and the prior denials are upheld. X is not medically necessary and non-certified

Upheld

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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

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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