

True Resolutions Inc.
Notice of Independent Review Decision

True Resolutions Inc.
An Independent Review Organization
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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 is a X who was injured on X. X sustained injury due to repetitive activities of work. X described numbness and tingling in the right upper extremity specifically in the hand and fingers

There are no office visits available during the provided records.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the requests for X were denied. Rationale for X: "ODG by MCG Last review/update date: X "Opioids for Chronic Pain Treatment type: Medications Not Recommended (generally)-NR Not recommended as a first-line treatment for chronic non-malignant pain and not recommended in patients at high risk for misuse, diversion use disorder." In this case, continued use of the medication would not be medically necessary as the patient does not have confirmed efficacy by way of a significant decrease in change in pain scores with a subsequent significant increase with a change in functionality. There were no statements of improved activities of daily living. Therefore, this request is not medically necessary. However, due to the nature of this medication, weaning is recommended. However, as peer-to-peer has not occurred to confirm the weaning amount, the request cannot be changed. Therefore, the requested X is not medically necessary." Rationale X: "ODG by MCG Last review/update date: X "X Treatment type: Medications Recommended (generally)-R Recommended; may be a first-line treatment option. ODG Criteria X may be indicated when ALL of the following are present (1): Appropriate clinical condition, as indicated by 1 or more of the following: o Anxiety, as indicated by ALL of the following (2) (3): Clinical condition is 1 or more of the following: o Fibromyalgia, and patient age 18

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years or older o Neuropathic pain, as indicated by ALL of the following: Age 18 years or older. Pain due to 1 or more of the following: Diabetic peripheral neuropathy Spinal cord injury o Postherpetic neuralgia, and patient age 18 years or older” In this case, continued use of the medication would not be medically necessary as the patient does not have confirmed efficacy by way of a significant decrease in pain scores with a subsequent significant increase with a change functionally. There were no statements of improved activities of daily living. Therefore, this request is not medically necessary. However, due to nature of this medication, weaning is recommended. However, as peer-to-peer has not occurred to confirm the weaning amount, the request cannot be changed. Therefore, the requested X is not medically necessary.” Rationale for X: “ODG by MCG Last review/update date: “X for Pain Treatment type: Medications recommended (generally)-R Recommended as an option in first-line treatment of neuropathic pain. “In this case, continued use of the medication would not be medically necessary as the patient does not have confirmed efficacy with a change in functionality. There were no statements of improved activities of daily living. Therefore, this request is not medically necessary. However, due to nature of this medication, weaning is recommended. However, as peer-to-peer has not occurred to confirm the weaning amount, the request cannot be changed. Therefore, the requested X is not medically necessary.” Rationale for X: “ODG by MCG Last review/update date: X for Pain Treatment type: Medications Other-X is a prescription short-acting X which is recommended for short-term (7-10 days) treatment of insomnia. ODG by MCG Last review/update date: X “Insomnia Treatment for Pain Treatment type: Psychological, Other Conditionally Recommended-CR Recommend that treatment be based on the etiology, with the medications recommended below. ODG Criteria Pharmacological agents should only be used after careful evaluation of potentially causes of sleep disturbance. Failure of sleep disturbance to resolved in a 7 to 10 day period may indicate a psychiatric and/or medial illness. (1) (EG 2) Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific components of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-days functioning.” In this case, continued use of the

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medication would not be medically necessary as the patient does not have confirmed efficacy with a change in functionality. There were no statements of improved activities of daily living. Therefore, this request is not medically necessary. However, due to nature of this medication, weaning is recommended. However, as peer-to-peer has not occurred to confirm the weaning amount, the request cannot be changed. Therefore, the requested X is not medically necessary.

Per a peer review and reconsideration / utilization review adverse determination letter dated X, MD non-certified the appeal requests for X. Rationale for Appeal: X: "The X evaluation noted that the claimant exhibited no signs of misuse, abuse, or diversion. The claimant had improved functioning and decreased pain levels by 70%, with pain reported as 2-3/10. The X. No physical examination findings were detailed. The previous request was modified for weaning purposes, as continued use of the medication would not be medically necessary. The claimant has not demonstrated confirmed efficacy, as there has been no significant decrease in pain scores or a notable improvement in functionality. There were no statements indicating improved activities of daily living. X is conditionally recommended by ODG by MCG guidelines and can be an option for the treatment of acute or chronic non-malignant musculoskeletal pain when first-line medications have been attempted and are not effective. However, current evidence-based guidelines do not recommend long-term use of this medication class due to the lack of evidence supporting its effectiveness in relieving pain over the long term, compared to the risks involved, such as dependency and abuse. The clinical records did not clearly demonstrate the extent of pain relief or functional improvement with the ongoing use of X. The current evaluation generally referenced functional improvement with medications and the X, but it is unclear how much pain relief is attributed to X versus the X. Additionally, the records did not detail recent risk assessments or urine drug screening results for compliance, as recommended by current evidence-based guidelines. Given these issues, which do not meet guideline recommendations, the request is not medically necessary. Therefore, the request is recommended noncertified." Rationale for Appeal: X: "X medications, including X, are commonly prescribed for the treatment of

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neuropathic pain, such as radiculopathy, ODG by MCG guidelines conditionally recommend the use of X for the treatment of neuropathic pain. However, the available records did not detail the specific efficacy of the prescribed X. The current evaluation generally referred to functional improvement with medications and the X, but it is unclear how much pain relief is attributed to X versus the X. Given these issues, which do not meet guideline recommendations, the request is not medically necessary. Therefore, the request is recommended non-certified.” Rationale for Appeal: X: “ODG by MCG guidelines conditionally recommend X for neuropathic pain. However, the available records did not detail the specific efficacy of the prescribed X. The current evaluation generally referred to functional improvement with medications and the X, but it is unclear how much pain relief is attributed to X versus the X. Given these issues, which do not meet guideline recommendations, the request is not medically necessary. Therefore, the request is recommended non-certified.” Rationale for Appeal: X: “ODG by MCG guidelines do not generally recommend the use of X except on a short-term basis for the treatment of X. The current evaluation of the claimant did not discuss the specific effectiveness of X in improving the claimants overall sleep quality or functional improvement Given these issues, which do not meet guideline recommendations, the request is not medically necessary. Therefore, the request is recommended non-certified.”

Thoroughly reviewed provided records including peer reviews.

The patient has chronic pain issues being managed at least by X. The documentation from the provider notes improved functioning and decrease in subjective pain. Specifically attributing what medications or treatments result in patient’s pain relief is not possible nor required by cited ODG criteria. Given provider also appears to be following safe opioid prescribing guidelines, requests for X are warranted given all these medications are necessary to lower the patient’s pain and improve their function. X are medically necessary and certified

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

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Thoroughly reviewed provided records including peer reviews.

The patient has chronic pain issues being managed at least by X. The documentation from the provider notes improved functioning and decrease in subjective pain. Specifically attributing what medications or treatments result in patient's pain relief is not possible nor required by cited ODG criteria. Given provider also appears to be following safe opioid prescribing guidelines, requests for X are warranted given all these medications are necessary to lower the patient's pain and improve their function. X are medically necessary and certified

Overtured

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