To reply to this email click here

PEER REVIEW REQUEST FORM

Date Submitted:	10/27/2022	**Due Date/Time:**	**10/28/2022 03:00PM**
Client Contact:	Bernirey Estacion, RN	Peer Vendor:	ExamWorks/NMR
Phone:	(629) 230-5526	Peer Vendor eMail:	clayton.langley@mitchell.com
Fax:	(615) 778-5135		
Email:	Bernirey_Estacion@gbtpa.com		

Claimant:	RICHARD PRESEDO	Employer:	SHERWIN WILLIAMS COMPANY
		Location:	SHERWIN-WILLIAMS COMPANY (WC PROGRAM) - 010733
Claim #:	010733-021026-WC-01	Carrier:	
DOI:	12/17/2019	Claims Examiner:	MIKE NICHOLAS
DOB:	12/22/1960	Review #:	5915173.01
Received Date:		TPA:	

Requesting Provider:	Joseph Cardinale, MD	# of Requests:	0
Phone:	(516) 536-2800	Jurisdiction:	NY
Specialty:	Anesthesiology,Pain Management	Review Level:	Pharmacy Level 2
		Review Type:	Prospective UR

Medical Records:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	UR Request	Joseph Cardinale, MD	2	10/19/2022	10/19/2022
2	Medical Records	Joseph Cardinale, MD	4	10/18/2022	10/18/2022
3	UR Request	Joseph Cardinale, MD	3	10/19/2022	10/22/2022
4	UR Request	Joseph Cardinale, MD	4	10/19/2022	10/25/2022
5	UR Request	Joseph Cardinale, MD	2	10/19/2022	10/19/2022
6	UR Request	Joseph Cardinale, MD	3	10/19/2022	10/22/2022
7	UR Request	Joseph Cardinale, MD	4	10/19/2022	10/25/2022

Treatment Requested:	cyclobenzaprine 10mg, Quantity 60, Days Supply 30, Type of Drug Generic, Refills Requested 0, Type of Prescription Refill/Renewal (Taken Within the Past Six Months), Route of Administration Oral/SL/Buccal (S5000); oxycodone 5-325, Quantity 75, Days Supply 30, Type of Drug Generic, Refills Requested 0, Type of Prescription Refill/Renewal (Taken Within the Past Six Months), Route of Administration Oral/SL/Buccal (S5000)
Diagnosis:	M54.17 Radiculopathy, lumbosacral region; G89.4 Chronic pain syndrome; M48.061 Spinal stenosis, lumbar region without neurogenic claudication
History of Condition:	
Source/Criteria/Ref:	New York Medical Treatment Guidelines /
Citation:	
Conclusion:	
Client Instructions	Guideline Variance: NY WC Drug Formulary & NY WCB MTG Non-Acute Pain - This is a Pharmacy Level 2 request, will send to Peer for further review. PA Due Date/Time: 10/28/2022 03:00 PM Requesting Provider Name/Specialty: Joseph Cardinale, MD Anesthesiology, Pain Management Compensable (Accepted) Body Part/s: Accepted claim left hip and left shoulder. Specific Instruction: Please review for medical necessity: cyclobenzaprine 10mg, Quantity 60, Days Supply 30, Type of Drug Generic, Refills Requested 0, Type of Prescription Refill/Renewal (Taken Within the Past Six Months), Route of Administration Oral/SL/Buccal (S5000); oxycodone 5-325, Quantity 75, Days Supply 30, Type of Drug Generic, Refills Requested 0, Type of Prescription Refill/Renewal (Taken Within the Past Six Months), Route of Administration Oral/SL/Buccal (S5000)

Treatment Request Details:

DOS Start Date	DOS End Date	Treatment	Description Text	CPT	Req Units	Auth Units	Body Part	Determination	Guideline
		Pharmacy	cyclobenzaprine 10mg, Quantity 60, Days Supply 30, Type of Drug Generic, Refills Requested 0, Type of Prescription Refill/Renewal (Taken Within the	S5000	60		Lower back muscles, excluding sacrum, coccyx, pelvis, vertebrae, disc, spinal cord		

			Past Six Months), Route of Administration Oral/SL/Buccal (S5000)						
		Pharmacy	oxycodone 5-325, Quantity 75, Days Supply 30, Type of Drug Generic, Refills Requested 0, Type of Prescription Refill/Renewal (Taken Within the Past Six Months), Route of Administration Oral/SL/Buccal (S5000)	S5000	75		Lower back muscles, excluding sacrum, coccyx, pelvis, vertebrae, disc, spinal cord		

NMR #747000 (Pre-Referral)

Click here to print

Comments

Client Due Date	10/28/2022 3:00 PMCDT
Referrer	Starling, Debra
Referrer Phone	(615) 778-5135
Referrer Email	debra_starling@gbtpa.com
Client	GALL-WC-GALL1 - GALLAGHER BASSETT - PEER REVIEWS
Turnaround Type	Standard
Date Created	10/27/2022 4:08 PMCDT
Referral Type	Peer Review
Line of Business	Work Comp
Review Type	Medical Necessity
Review Level	Pharmacy Level 2
Review is Addendum	
Review Timing	Prospective UR
State of Jurisdiction	NY
Last Name	Presedo
First Name	Richard
Claim Number	010733-021026-WC-01
Gender	Unknown
Date of Birth	12/22/1960
Job Title	
Date of Disability/Injury	12/17/2019
Diagnosis(es)	M54.17 Radiculopathy, lumbosacral region; G89.4 Chronic pain syndrome; M48.061 Spinal stenosis lumbar region without neurogenic claudication
Previous Treatment	
Review Period	
SSN	
Case Summary	Guideline Variance: NY WC Drug Formulary & NY WCB MTG Non-Acute Pain - This is a Pharmacy Level 2 request, will send to Peer for further review.PA Due Date/Time: 10/28/2022 03:00 PM Requesting Provider Name/Specialty: Joseph Cardinale, MD Anesthesiology, Pain ManagementCompensable (Accepted) Body Part/s: Accepted claim left hip and leftshoulder.Specific Instruction: Please review for medical necessity: cyclobenzaprine 10mg, Quantity 60, Days Supply 30, Type of Drug Generic, Refills Requested 0, Type of Prescription Refill/Renewal (Taken Within th Past Six Months), Route of Administration Oral/SL/Buccal (S5000); oxycodone 5-325, Quantity 75, Days Supply 30, Type of Drug Generic, Refills Requested 0, Type of Prescription Refill/Renewal (Taken Within the Past Six Months), Route of Administration Oral/SL/Buccal (S5000)
Location	SHERWIN-WILLIAMS COMPANY (WC PROGRAM) - 010733
Employer	SHERWIN WILLIAMS COMPANY
Street	
City	
State	
Zip Code	
Contact Provider(s)	No
Provider Specialty	Anesthesiology,Pain Management
Provider Phone Number	(516) 536-2800
Number of Questions	1
Question 01	
Special Requirements	

Attachments

Client Uploads

No Document Attached

Documentation Reviewed

ref.DO-00-2181-278_10-25-2022-21-06_5.pdf

ref.DO-00-2181-317_10-25-2022-21-02_2.pdf

ref.DO-00-2181-318_10-25-2022-21-02_1.pdf

ref.DO-00-2219-648_10-25-2022-21-02_3.pdf

ref.DO-00-2219-649_10-25-2022-21-06_6.pdf

ref.DO-00-2242-522_10-25-2022-21-06_7.pdf

ref.DO-00-2243-200_10-25-2022-21-02_4.pdf

ref.R.doc

Reports

No Document Attached

NEW YORK STATE | Workers' Compensation Board

PRIOR AUTHORIZATION REQUEST: MEDICATION

Listed below are details of a Prior Authorization Request (PAR) that was submitted to request a medication. Upon identification of the claim administrator, they will be required to respond within 4 calendar days; parties will be notified of the outcome.

CLAIM INFORMATION

WCB Case #	Date of Injury	Claim Admin Claim #
G2708320	12/17/2019	010733021026WC01

Patient Name PRESEDO, RICHARD J

Address 16611 20TH RD
WHITESTONE, NY 113574001

SSN XXX-XX-1694 **DOB** 12/22/1960 **Gender** Male

Employer Name THE SHERWIN WILLIAMS CO

Address 80 EXPRESS ST
PLAINFIEW, NY 11803

Insurer Name Sherwin-Williams Company Attn: Jessica Oslin **Insurer ID** W611503

Address 101 PROSPECT AVENUE NW
CLEVELAND, OH 44115

Claim Admin Name Gallagher Bassett Services Inc **Claim Admin ID** T100033

Address

HEALTH CARE PROVIDER INFORMATION

Name Cardinale, Joseph

Address 1101 Stewart Avenue
Garden City, NY 11530

Type Physician

WCB Auth # 242510-6 **NPI** 1093980625

PRIOR AUTHORIZATION REQUEST DETAILS

1.

Therapeutic Category	Narcotic
Medication (Name/Strength)	oxycodone 5-325
Quantity	75
Days Supply	30
Type of Drug	Generic
Refills Requested	0
Type of Prescription	Refill/Renewal (Taken Within the Past Six Months)
Route of Administration	Oral/SL/Buccal

STATEMENT OF MEDICAL NECESSITY / SUPPORTING MEDICAL DOCUMENTATION

Statement of Medical Necessity: see attached

Supporting documentation was provided as a part of this request.

PROVIDER'S ATTESTATION

By submission of this request for prior authorization, I certify that my statements are true and correct, and I do not have a substantially similar request pending.

Provider Name Cardinale, Joseph **Date** 10/19/2022

NEW YORK STATE | Workers' Compensation Board

PRIOR AUTHORIZATION REQUEST: MEDICATION

Listed below are details of a Prior Authorization Request (PAR) that was submitted to request a medication. Upon identification of the claim administrator, they will be required to respond within 4 calendar days; parties will be notified of the outcome.

CLAIM INFORMATION

WCB Case #	Date of Injury	Claim Admin Claim #
G2708320	12/17/2019	010733021026WC01

Patient Name PRESEDO, RICHARD J

Address 16611 20TH RD
WHITESTONE, NY 113574001

SSN XXX-XX-1694 **DOB** 12/22/1960 **Gender** Male

Employer Name THE SHERWIN WILLIAMS CO

Address 80 EXPRESS ST
PLAINFIEW, NY 11803

Insurer Name Sherwin-Williams Company Attn: Jessica Oslin **Insurer ID** W611503

Address 101 PROSPECT AVENUE NW
CLEVELAND, OH 44115

Claim Admin Name Gallagher Bassett Services Inc **Claim Admin ID** T100033

Address

HEALTH CARE PROVIDER INFORMATION

Name Cardinale, Joseph

Address 1101 Stewart Avenue
Garden City, NY 11530

Type Physician

WCB Auth # 242510-6 **NPI** 1093980625

PRIOR AUTHORIZATION REQUEST DETAILS

1.

Therapeutic Category	Skeletal Muscle Relaxant
Medication (Name/Strength)	cyclobenzaprine 10mg
Quantity	60
Days Supply	30
Type of Drug	Generic
Refills Requested	0
Type of Prescription	Refill/Renewal (Taken Within the Past Six Months)
Route of Administration	Oral/SL/Buccal

STATEMENT OF MEDICAL NECESSITY / SUPPORTING MEDICAL DOCUMENTATION

Statement of Medical Necessity: see attached

Supporting documentation was provided as a part of this request.

PROVIDER'S ATTESTATION

By submission of this request for prior authorization, I certify that my statements are true and correct, and I do not have a substantially similar request pending.

Provider Name Cardinale, Joseph **Date** 10/19/2022

Name: RICHARD JAMES PRESEDO
Address: 166-11 20TH RD
WHITESTONE, NY 11357

Date of Visit: Oct 18 2022
MRN: 13414265
DOB: 12/22/1960

Reason For Visit

RICHARD PRESEDO is being seen for a follow-up pain management visit. Pp

History of Present Illness

10/18/2022 Left L4-5, L5-S1 TFESI on 10/05/2022

Rx refill

Injury Details:
Location of Problem: lower back.
Cause of Accident/Injury: work related.
Date of Accident/Injury: 12/17/2019.
On a scale of 0-10, patient rated 9 for pain when active.
On a scale of 0-10, patient rated 7 for pain at rest.
Pain Quality: burning, dull/aching, radiating, sharp, shooting, stabbing, throbbing, tightness, tingling.
Pain is Radiating: yes.
Pain is constant.
Pain affects the following activities: household chores, leisure, work, sleep.
Pain improves with: meds.
Pain worsen with: standing, walking.
Patient needs support to ambulate: yes.
Patient has been treated for this problem before: yes. Date of Past Treatment: 04/2022.
Patient has had surgery for this problem in the past: no.
Patient has had physical therapy for this in the past: no.
Patient has completed studies for this problem? yes.
Sports Injury:
Patient is currently playing sports: no.
Patient is currently injured and not playing sports: no.
Worker's compensation injury: yes.
Patient reported injury to employer: yes.
Injection:
This patient has had an injection before: yes.
Patient has had a reaction to this injection: no.
Prior injections have helped with the pain: yes. Pain Improvement By: 60%.

Current Meds

Cyclobenzaprine HCl - 10 MG Oral Tablet; TAKE 1 TABLET TWICE DAILY AS NEEDED
Gabapentin 600 MG Oral Tablet; TAKE 1 TABLET 3 TIMES DAILY
HYDROcodone-Acetaminophen 5-325 MG Oral Tablet; TAKE 1 TABLET EVERY 4 TO 6 HOURS AS NEEDED FOR PAIN. MDD:3 mdd
HYDROcodone-Acetaminophen 5-325 MG Oral Tablet; TAKE 1 TABLET EVERY 4 TO 6 HOURS AS NEEDED FOR PAIN. MDD:MDD 3/D
Ketorolac Tromethamine 10 MG Oral Tablet; TAKE 1 TABLET EVERY 6 HOURS AS NEEDED
Meloxicam 15 MG Oral Tablet; TAKE 1 TABLET EVERY DAY AS NEEDED
oxyCODONE-Acetaminophen 5-325 MG Oral Tablet; TAKE 1 TO 2 TABLETS EVERY 4 TO 6 HOURS AS NEEDED FOR PAIN. MDD:6 tab

Allergies

No Known Allergies

Review of Systems

Constitutional, Eyes, ENT, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Integumentary, Neurological, Psychiatric, Endocrine and Heme/Lymph review of systems are otherwise negative except as noted in HPI.

Vitals
Vital Signs

	Recorded: 18Oct2022 01:46PM
Height	6 ft 2 in
Weight	226 lb
BMI Calculated	29.02 kg/m2
BSA Calculated	2.29

Physical Exam

Neurologic: normal coordination, normal DTR UE/LE , normal sensation and normal mood and affect.
Skin: normal skin, no rash, no ulcers and no lesions.
Lymphatic: no obvious lymphadenopathy in areas examined.

Examination of the spine is as follows:
Inspection: no atrophy, no erythema, no ecchymosis, no palpable masses, no swelling.
Palpation (Bilateral): no lumbar paraspinal spasm, no lumbar paraspinal tenderness, no thoracic paraspinal spasm, no thoracic paraspinal tenderness, no sciatic nerve tenderness.
ROM: full ROM with no pain.
Lumbar: forward flexion 90 degrees, extension 30 degrees, left lateral bending 30 degrees, left lateral rotation 30 degrees, right lateral bending 30 degrees, right lateral rotation 30 degrees
Thoracic: forward flexion 45 degrees, extension 45 degrees, left lateral bending 40 degrees, right lateral bending 40 degrees
Strength: motor exam is 5/5 throughout both lower extremities with normal tone, motor exam is non-focal throughout both lower extremities, left hip flexion 5/5, left quadriceps 5/5, left hamstring 5/5, left dorsiflexors 4/5, left plantor flexors 5/5, left extensor hallicus longus 5/5, right hip flexion 5/5, right quadriceps 5/5, right hamstring 5/5, right dorsiflexors 5/5, right plantor flexors 5/5, right extensor hallicus longus 5/5 . Poor control of the lateral 4 toes. Pedal pulses are intact and easily palpable.
Testing (Left): positive equivocal straight leg raise, positive Faber test reproduction of pain into groin.
Testing (Bilateral): negative Kemp maneuver facet loading, negative straight leg raise, negative sitting straight leg raise, negative equivocal straight leg raise, negative contralateral straight leg raise, negative Faber test reproduction of pain into groin, negative tight hamstring.
Neuro: light touch intact throughout both lower extremities, achilles and patella reflexes are symmetrical, clonus not sustained at ankle, sensory exam non-focal throughout both lower extremities, Babinski test negative bilaterally.
Subjective decrease sensation to light touch at: left lower extremity below knee, left lower extremity above knee.
Gait: antalgic, ambulation with cane.

Assessment
Chronic pain disorder (338.4) (G89.4)
Lumbosacral radiculitis (724.4) (M54.17)
Spinal stenosis of lumbar region at multiple levels (724.02) (M48.061)

Discussion/Summary
Medication risks reviewed. Surgical risks reviewed. 60% relief pp with improved rom and adls
will repeat L L45 L5S1 TFESI for cumulative relief

scheduled for hip replacement with dr germano 11/16

will refill meds; rotate to oxy, increase gabapentin to 800mg tid

After discussing various treatment options with the patient including but not limited to oral medications, physical therapy, exercise, modalities as well as interventional spinal injections, we have decided with the following plan

I personally reviewed the MRI/CT scan images and agree with the radiologist's report. The radiological findings were discussed with the patient.

The risks, benefits, contents and alternatives to injection were explained in full to the patient. Risks outlined include but are not limited to infection,sepsis, bleeding, post-dural puncture headache, nerve damage, temporary increase in pain, syncopal episode, failure to resolve symptoms, allergic reaction, symptom recurrence, and elevation of blood sugar in diabetics. Cortisone may cause immunosuppression. Patient understands the risks. All questions were answered. After discussion of options, patient requested an injection. Information regarding the injection was given to the patient. Which medications to stop prior to the injection was explained to the patient as well.

Follow up in 1-2 weeks post injection for re-evaluation.

Conservative Care
Continue Home exercises, stretching, activity modification, physical therapy, and conservative care.

Medication Renewal

The patient is stable on current pain medication with analgesia and without notable side effects or any obvious aberrant behaviors exhibited.
There is clinically meaningful improvement in pain and function that outweighs risks to patient safety. I have discussed risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy. Pain agreement has been signed.
Will renew medication today.

Follow up in 4-6 weeks
Follow up in 4-6 weeks or sooner if there are any problems.

Conservative Care
Continue Home exercises, stretching, activity modification, physical therapy, and conservative care.

NO NEW FINDINGS
Patient denies new numbness, tingling, weakness, fevers, chills and bowel/bladder incontinence

PMP
I have consulted the PMP Registry for the purpose of reviewing the patient's controlled substance

.

Plan

Chronic pain disorder

Start: Gabapentin 800 MG Oral Tablet; TAKE 1 TABLET 3 TIMES DAILY
COVID-19 PCR (Nasopharyngeal Swab); Status:Active; Requested for:18Oct2022;
Pt consents to e-results? : No
Renew: Cyclobenzaprine HCl - 10 MG Oral Tablet; TAKE 1 TABLET TWICE DAILY AS NEEDED
Renew: Meloxicam 15 MG Oral Tablet; TAKE 1 TABLET EVERY DAY AS NEEDED

Lumbosacral radiculitis

Follow-up visit in 1 month Outpatient . Status: Hold For - Scheduling Requested for: 18Nov2022

Nontraumatic complete tear of right rotator cuff

Renew: oxyCODONE-Acetaminophen 5-325 MG Oral Tablet (Percocet); TAKE 1 TO 2

TABLETS EVERY 4 TO 6 HOURS AS NEEDED FOR PAIN. MDD:3 tab

Spinal stenosis of lumbar region at multiple levels

OC PM Procedure Booking Form Outpatient Not required Status: Active Requested for: 18Oct2022

Electronically signed by : JOSEPH CARDINALE, MD; Oct 18 2022 2:16PM EST (Author)

NEW YORK STATE | Workers' Compensation Board

PRIOR AUTHORIZATION REQUEST: MEDICATION

Listed below are details of a Prior Authorization Request (PAR) that was submitted to request a medication. The claim administrator has denied all or part of the request; please carefully review all items.

To the health care provider: For any medication that was **Denied**, you may request review by the claim administrator's physician using OnBoard no later than 11/01/2022.
Note: If present, a Level 2 Insurer Response supersedes a Level 1 Insurer Response.

CLAIM INFORMATION

WCB Case #	Date of Injury	Claim Admin Claim #
G2708320	12/17/2019	010733021026WC01

Patient Name PRESEDO, RICHARD J

Address 16611 20TH RD
WHITESTONE, NY 11357-4001

SSN XXX-XX-1694 **DOB** 12/22/1960 **Gender** Male

Employer Name THE SHERWIN WILLIAMS CO

Address 80 EXPRESS ST
PLAINFIEW, NY 11803

Insurer Name THE SHERWIN-WILLIAMS COMPANY
ANTHONY COLANGELO MGR WC

Insurer ID W611503

Address 101 PROSPECT AVENUE NW
CLEVELAND, OH 44115

Claim Admin Name Gallagher Bassett Services, Inc.

Claim Admin ID T100033

Address

HEALTH CARE PROVIDER INFORMATION

Name Cardinale, Joseph

Address 1101 Stewart Avenue
Garden City, NY 11530

Type Physician

WCB Auth # 242510-6

NPI 1093980625

PRIOR AUTHORIZATION REQUEST DETAILS

1.

Therapeutic Category	Skeletal Muscle Relaxant
Medication (Name/Strength)	cyclobenzaprine 10mg
Quantity	60
Days Supply	30
Type of Drug	Generic
Refills Requested	0
Type of Prescription	Refill/Renewal (Taken Within the Past Six Months)
Route of Administration	Oral/SL/Buccal

STATEMENT OF MEDICAL NECESSITY / SUPPORTING MEDICAL DOCUMENTATION

Statement of Medical Necessity: see attached

Supporting documentation was provided as a part of this request.

PROVIDER'S ATTESTATION

By submission of this request for prior authorization, I certify that my statements are true and correct, and I do not have a substantially similar request pending.

Provider Name Cardinale, Joseph **Date** 10/19/2022

LEVEL 1 INSURER RESPONSE

1.	Authorization Requested		Insurer Response	
	Therapeutic Category	Skeletal Muscle Relaxant	**Insurer Response**	Deny
	Medication (Name/Strength)	cyclobenzaprine 10mg	**Denial Category**	Medical Reasons
	Quantity	60	**Denial Reason**	Continuation of Medication - no documentation of efficacy
	Days Supply	30	**Rationale**	No indication of severe muscle spasms in PE. Thus, request is not certified.
	Type of Drug	Generic		
	Refills Requested	0		
	Type of Prescription	Refill/Renewal (Taken Within the Past Six Months)		
	Route of Administration	Oral/SL/Buccal		

Claim Apportioned No

Name of the Reviewer Vera Mae Talplacido **Date** 10/22/2022

Reviewer Title L1 Reviewer, RN

NEW YORK STATE | Workers' Compensation Board

PRIOR AUTHORIZATION REQUEST: MEDICATION

Listed below are details of a Prior Authorization Request (PAR) that was submitted to request a medication. The claim administrator has denied all or part of the request; please carefully review all items.

To the health care provider: For any medication that was **Denied**, you may request review by the claim administrator's physician using OnBoard no later than 11/01/2022.
Note: If present, a Level 2 Insurer Response supersedes a Level 1 Insurer Response.

CLAIM INFORMATION

WCB Case #	Date of Injury	Claim Admin Claim #
G2708320	12/17/2019	010733021026WC01

Patient Name PRESEDO, RICHARD J

Address 16611 20TH RD
WHITESTONE, NY 11357-4001

SSN XXX-XX-1694 **DOB** 12/22/1960 **Gender** Male

Employer Name THE SHERWIN WILLIAMS CO

Address 80 EXPRESS ST
PLAINFIEW, NY 11803

Insurer Name THE SHERWIN-WILLIAMS COMPANY
ANTHONY COLANGELO MGR WC **Insurer ID** W611503

Address 101 PROSPECT AVENUE NW
CLEVELAND, OH 44115

Claim Admin Name Gallagher Bassett Services, Inc. **Claim Admin ID** T100033

Address

HEALTH CARE PROVIDER INFORMATION

Name Cardinale, Joseph

Address 1101 Stewart Avenue
Garden City, NY 11530

Type Physician

WCB Auth # 242510-6 **NPI** 1093980625

PRIOR AUTHORIZATION REQUEST DETAILS

1.

Therapeutic Category	Narcotic
Medication (Name/Strength)	oxycodone 5-325
Quantity	75
Days Supply	30
Type of Drug	Generic
Refills Requested	0
Type of Prescription	Refill/Renewal (Taken Within the Past Six Months)
Route of Administration	Oral/SL/Buccal

STATEMENT OF MEDICAL NECESSITY / SUPPORTING MEDICAL DOCUMENTATION

Statement of Medical Necessity: see attached

Supporting documentation was provided as a part of this request.

PROVIDER'S ATTESTATION

By submission of this request for prior authorization, I certify that my statements are true and correct, and I do not have a substantially similar request pending.

Provider Name Cardinale, Joseph **Date** 10/19/2022

LEVEL 1 INSURER RESPONSE

1.	Authorization Requested		Insurer Response	
	Therapeutic Category	Narcotic	**Insurer Response**	Deny
	Medication (Name/Strength)	oxycodone 5-325	**Denial Category**	Medical Reasons
	Quantity	75	**Denial Reason**	Continuation of Medication - no documentation of efficacy
	Days Supply	30	**Rationale**	Continuation of medication. Guidelines require ongoing assessment/monitoring. There was no documentation of updated urine drug screen. (This is not to be construed as a recommendation to abruptly discontinue this medication but a titration schedule would be left to the discretion of the treating physician.)
	Type of Drug	Generic		
	Refills Requested	0		
	Type of Prescription	Refill/Renewal (Taken Within the Past Six Months)		
	Route of Administration	Oral/SL/Buccal		

Claim Apportioned No

Name of the Reviewer Vera Mae Talplacido **Date** 10/22/2022

Reviewer Title L1 Reviewer, RN

NEW YORK STATE | Workers' Compensation Board

PRIOR AUTHORIZATION REQUEST: MEDICATION

Listed below are details of a Prior Authorization Request (PAR) that was submitted to request a medication. In response to the claim administrator's Level 1 denial of all or part of the request, Joseph Cardinale has requested review by Level 2; parties will be notified of the outcome.
Note: If present, a Level 2 Insurer Response supersedes a Level 1 Insurer Response.

CLAIM INFORMATION

WCB Case #	Date of Injury	Claim Admin Claim #
G2708320	12/17/2019	0107330210 26WC01

Patient Name PRESEDO, RICHARD J

Address 16611 20TH RD
WHITESTONE, NY 11357-4001

SSN XXX-XX-1694 **DOB** 12/22/1960 **Gender** Male

Employer Name THE SHERWIN WILLIAMS CO

Address 80 EXPRESS ST
PLAINFIEW, NY 11803

Insurer Name THE SHERWIN-WILLIAMS COMPANY
ANTHONY COLANGELO MGR WC **Insurer ID** W611503

Address 101 PROSPECT AVENUE NW
CLEVELAND, OH 44115

Claim Admin Name Gallagher Bassett Services, Inc. **Claim Admin ID** T100033

Address

HEALTH CARE PROVIDER INFORMATION

Name Cardinale, Joseph

Address 1101 Stewart Avenue
Garden City, NY 11530

Type Physician

WCB Auth # 242510-6 **NPI** 1093980625

PRIOR AUTHORIZATION REQUEST DETAILS

1.

Therapeutic Category	Narcotic
Medication (Name/Strength)	oxycodone 5-325
Quantity	75
Days Supply	30
Type of Drug	Generic
Refills Requested	0
Type of Prescription	Refill/Renewal (Taken Within the Past Six Months)
Route of Administration	Oral/SL/Buccal

STATEMENT OF MEDICAL NECESSITY / SUPPORTING MEDICAL DOCUMENTATION

Statement of Medical Necessity: see attached

Supporting documentation was provided as a part of this request.

PROVIDER'S ATTESTATION

By submission of this request for prior authorization, I certify that my statements are true and correct, and I do not have a substantially similar request pending.

Provider Name Cardinale, Joseph **Date** 10/19/2022

LEVEL 1 INSURER RESPONSE

1.	Authorization Requested		Insurer Response	
	Therapeutic Category	Narcotic	**Insurer Response**	Deny
	Medication (Name/Strength)	oxycodone 5-325	**Denial Category**	Medical Reasons
	Quantity	75	**Denial Reason**	Continuation of Medication - no documentation of efficacy
	Days Supply	30	**Rationale**	Continuation of medication. Guidelines require ongoing assessment/monitoring. There was no documentation of updated urine drug screen. (This is not to be construed as a recommendation to abruptly discontinue this medication but a titration schedule would be left to the discretion of the treating physician.)
	Type of Drug	Generic		
	Refills Requested	0		
	Type of Prescription	Refill/Renewal (Taken Within the Past Six Months)		
	Route of Administration	Oral/SL/Buccal		

Claim Apportioned No

Name of the Reviewer Vera Mae Talplacido **Date** 10/22/2022

Reviewer Title L1 Reviewer, RN

LEVEL 2 REVIEW REQUEST

Providers relevant clinical information (see below or attached) to support the Level 2 request for review, specifically addressing the issues raised in the Level 1 denial or partial approval:

this medication is medically necessary, eliminates need for stronger opioid meds; he will have urine test done on follow up; all prior urine tests have been consistent

Provider Name Cardinale, Joseph **Date** 10/25/2022

NEW YORK STATE | Workers' Compensation Board

PRIOR AUTHORIZATION REQUEST: MEDICATION

Listed below are details of a Prior Authorization Request (PAR) that was submitted to request a medication. In response to the claim administrator's Level 1 denial of all or part of the request, Joseph Cardinale has requested review by Level 2; parties will be notified of the outcome.
Note: If present, a Level 2 Insurer Response supersedes a Level 1 Insurer Response.

CLAIM INFORMATION

WCB Case #	Date of Injury	Claim Admin Claim #
G2708320	12/17/2019	0107330210 26WC01

Patient Name PRESEDO, RICHARD J

Address 16611 20TH RD
WHITESTONE, NY 11357-4001

SSN XXX-XX-1694 **DOB** 12/22/1960 **Gender** Male

Employer Name THE SHERWIN WILLIAMS CO

Address 80 EXPRESS ST
PLAINFIEW, NY 11803

Insurer Name THE SHERWIN-WILLIAMS COMPANY
ANTHONY COLANGELO MGR WC **Insurer ID** W611503

Address 101 PROSPECT AVENUE NW
CLEVELAND, OH 44115

Claim Admin Name Gallagher Bassett Services, Inc. **Claim Admin ID** T100033

Address

HEALTH CARE PROVIDER INFORMATION

Name Cardinale, Joseph

Address 1101 Stewart Avenue
Garden City, NY 11530

Type Physician

WCB Auth # 242510-6 **NPI** 1093980625

PRIOR AUTHORIZATION REQUEST DETAILS

1.

Therapeutic Category	Skeletal Muscle Relaxant
Medication (Name/Strength)	cyclobenzaprine 10mg
Quantity	60
Days Supply	30
Type of Drug	Generic
Refills Requested	0
Type of Prescription	Refill/Renewal (Taken Within the Past Six Months)
Route of Administration	Oral/SL/Buccal

STATEMENT OF MEDICAL NECESSITY / SUPPORTING MEDICAL DOCUMENTATION

Statement of Medical Necessity: see attached

Supporting documentation was provided as a part of this request.

PROVIDER'S ATTESTATION

By submission of this request for prior authorization, I certify that my statements are true and correct, and I do not have a substantially similar request pending.

Provider Name Cardinale, Joseph **Date** 10/19/2022

LEVEL 1 INSURER RESPONSE

1.	Authorization Requested		Insurer Response	
	Therapeutic Category	Skeletal Muscle Relaxant	**Insurer Response**	Deny
	Medication (Name/Strength)	cyclobenzaprine 10mg	**Denial Category**	Medical Reasons
	Quantity	60	**Denial Reason**	Continuation of Medication - no documentation of efficacy
	Days Supply	30	**Rationale**	No indication of severe muscle spasms in PE. Thus, request is not certified.
	Type of Drug	Generic		
	Refills Requested	0		
	Type of Prescription	Refill/Renewal (Taken Within the Past Six Months)		
	Route of Administration	Oral/SL/Buccal		

Claim Apportioned No

Name of the Reviewer Vera Mae Talplacido **Date** 10/22/2022

Reviewer Title L1 Reviewer, RN

LEVEL 2 REVIEW REQUEST

Providers relevant clinical information (see below or attached) to support the Level 2 request for review, specifically addressing the issues raised in the Level 1 denial or partial approval:

pt has radicular pain and cramping which is alleviated with cyclobenzaprine; he is stable on this medication >6 months, alleviates pain and cramping as well as eliminates need to increase opioid meds

Provider Name Cardinale, Joseph **Date** 10/25/2022