

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

DATE OF REVIEW: DECEMBER 3, 2007
AMENDED DECEMBER 14, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Under dispute is the medical necessity of medications: 1) Talwin, 2) Neurontin 600MG 2-3xday, 3) Zoloft 100 every day, 4) Flexeril 10 mg tid, 5) Nexium, 4 mg every day, 6 months refill for each

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board-certified Internal Medicine.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Talwin: The denial of this medication is **upheld**.

Neurontin: The denial of this medication is **overturned**.

Zoloft: The denial of this medication is **overturned**.

Flexeril: The denial of this medication is **upheld**.

Nexium: The denial of this medication is **upheld**.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notification of Case Assignment, Medical Records from Requestor, Respondent, Treating Doctor (s), including:

Carrier correspondence

Adverse Determination Letters, 11/9/07, 10/23/07

ODG Guidelines and Treatment Guidelines

Letter from Law Offices of, 11/21/07

Dr., 8/15/06, 1/25/07, 4/19/07, 7/19/07

Letters from, 8/4/06, 8/28/07

RME, MD, 1/16/06 (and clarification letter dated 1/17/06)

Cervical Myelogram, 10/31/03

D.O., 10/15/03, 11/7/03, 12/15/03, 1/13/04, 2/10/04, 3/9/04, 4/7/04, 6/8/04, 7/9/04, 8/3/04, 9/8/04, 10/6/04, 11/2/04, 11/30/04, 12/28/04, 1/24/05, 2/23/05, 3/25/05, 4/22/05, 5/24/05, 6/22/05, 8/10/05, 9/9/05, 10/7/05, 11/9/05, 12/12/05, 1/11/06, 3/13/06, 4/12/06, 5/10/06, 6/9/06, 7/11/06

Radiology Review, Dr., 3/3/04

7/28/04

Case Conference Notes, 8/3/06, 8/31/06, 9/7/06

P.A.-C, MMSC, 6/16/06

M.A., LPC, 6/30/06

PhD, Psychologist, 7/25/06, 8/31/06

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant injured her lower back in xx/xx. She underwent 2-level fusion in March 2000 with a repeat fusion in 2001. She completed a pain management program in 2006. Current treatment consists of periodic visits with her treating physician for refill of medications.

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

I have reviewed the applicable guidelines and the peer-reviewed medical literature concerning the use of medications for the treatment of chronic low back pain.

Talwin: the long-term use of opioids is not recommended. Though they may be useful in the first two weeks of pain, their use beyond this time period is not supported by the literature. The denial of this medication is **upheld**.

Neurontin: the use of this medication is recommended for neuropathic pain. Several office notes document sensory signs and symptoms, indicating nerve involvement. The denial of this medication is **overturned**.

Zoloft: the use of anti-depressants is recommended as an option for chronic low back pain. The denial of this medication is **overturned**.

Flexeril: the use of muscle relaxants is recommended as an option in acute cases. However, their use is not supported in chronic low back pain. The denial of this medication is **upheld**.

Nexium: the use of proton pump inhibitors is not indicated in the treatment of chronic low back pain. The denial of this medication is **upheld**.

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
- AHCPR- 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
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE THE COCHRANE REVIEW SERIES ON LOW BACK PAIN
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)