



**DATE OF REVIEW:** 6/18/07

**IRO CASE #:**

**NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Determine the medical necessity for the previously denied Lyrica 50 mg tab 3 times per day.

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

Texas licensed.

**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)

The previously denied request for Lyrica 50 mg tab 3 times per day.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Claimant Letter dated 6/11/07.
- Fax Cover Sheet dated 6/11/07, 6/7/07, 6/6/07.
- Notice to CompPartners, INC. Of Case Assignment dated 6/7/07.
- Request Form dated 6/4/07.
- Prospective\Concurrent Review Determination dated 6/4/07, 5/29/07.
- Utilization Review Agent dated 6/4/07.
- Office Visit dated 5/25/07.
- Follow-up Office Visit dated 5/23/07, 4/25/07.
- Providers Notes dated 4/10/07.
- Operative Report dated 3/1/07, 10/3/06.
- Peer Reviewer's Outline dated (unspecified).
- Article dated (unspecified).
- Form for Requesting a Review by an Independent Review Organization (IRO).
- Additional Physicians or Health Care Providers dated (unspecified).
- Name of Party Requesting IRO dated (unspecified).
- Workers' Compensation (WC) Health Care Network Information dated (unspecified).
- Denial Information dated (unspecified).

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

**Patient's age:** xx  
**Gender:** Female  
**Date of Injury:** xx/x/xx/xx  
**Mechanism of injury:** Kneeling on the floor.

**Diagnoses:**

1. Left lower extremity peripheral neuropathy.
2. Status-post left knee surgery x2.

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

From the information submitted for this review, it appears that this patient had a work-related injury involving the left knee on xx/xx/xx. Subsequent to the injury, the claimant underwent an arthroscopic anterior cruciate ligament (ACL) reconstruction with patellar tendon graft performed on 10/3/06 by, MD. Despite post-surgical rehabilitation and interferential pain management injections to the left knee joint, the claimant continued to have left knee pain and underwent a second left knee arthroscopic procedure, performed on 3/1/07, which revealed a healed ACL reconstruction with adhesive scar and cellulitis. Following this, the patient continued with complaints of sharp, burning, shooting pain, specifically at the level of the left knee, rated on a visual analog scale (VAS) score of 5/10. The patient was referred to Dr. (pain management specialist), who diagnosed this patient with a peripheral neuropathy, and on 4/10/07, this patient was started on Lyrica medication which reportedly, in follow-up visits, has substantially improved this patient's left lower extremity symptoms, including burning pain and tingling sensation. Medication management by Dr. has afforded this patient return to the workforce to include six-hour days. It is the recommendation by this peer reviewer that the medication named Lyrica is approved. Not only is there documentation of clinical benefit, but as well functional improvement from the use of this medication. Lyrica was approved by the FDA for diabetic neuropathy and postherpetic neuralgia. Its usage, at this time, for the claimant's left knee peripheral neuropathy is an off-label indication. This medication is basically no different than Neurontin (gabapentin) of which its off-label usage has been found to have some utility for neuropathic pain symptoms (i.e., shooting type, burning, and associated numbness and tingling). Based on the patient's clinical and objective findings, the medication is medically agreeable and appropriate.

## **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.  
Antiepilepsy Drugs (AED's) for Chronic Pain.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.
- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).  
Adjunct Analgesics for the Treatment of Neuropathic Pain: Evaluating efficacy and safety profiles by Forde, G. J., Family Practice. 2007, Feb; 56(2): 3-12.

**CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.**

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