

DATE OF REVIEW: 10/31/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lamisil 250mg tablets

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

The TMF physician reviewer is board certified in family practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the Lamisil 250mg tablets are medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Appeal Receipt after Notification of Determination – 09/05/07
2. Request for a Review by an Independent Review Organization – 08/20/07
3. Office visit notes from Dr. – 12/15/03 to 08/01/07

4. Office visit notes from Dr. – 08/13/01
5. Office visit notes from Dr. – 02/02/98 to 01/06/99
6. Laboratory reports 11/16/04 to 06/11/07
7. Letter to TMF – 10/01/07
8. notes – 08/06/07
9. Letter of Adverse Determination – 09/25/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient has been diagnosed with onychomycosis of the great toenails bilaterally and the treating physician has ordered Lamisil tablets as treatment.

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

This patient has a diagnosis of onychomycosis and the notes indicate that the diagnosis was confirmed by stain or culture. Onychomycosis does not respond to topical agents and such oral agents as Lamisil or Sporanox are indicated. The indications for treatment include 1) a history of cellulitis to the lower extremity, 2) associated diabetes or other risk factors, 3) discomfort or pain associated with infected nails, 4) patient desire for cosmetic reasons. The last two do not include co-morbidities and as such would be independent indications for treatment.

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 (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**