

# True Resolutions Inc.

An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW:** May 6, 2008

**IRO CASE #:**

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

Lortab, 10mg qid-lumbar region

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

MD, Board Certified in Physical Medicine and Rehab

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Adverse Determination Letters 2/22/08,  
Correspondence and records Dr.  
Correspondence Attorney  
Medical Records Dr.  
Medical Record Dr.  
Medical Record Dr.  
Medical Records Dr.  
Cervical Xray Report BSA  
Partial Designated Doctor Note Dr. 8/8/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This man sustained his original injury on . He had a cervical discectomy and fusion (C4-7) and subsequently developed right shoulder pain and low back pain. He had been on

Duragesic for his pain. He had a dorsal column stimulator inserted by Dr. in 2003 for the cervical pain. Dr. noted it was helping some (2004). He underwent a rotator cuff repair in 2004 and continued to have pain in his shoulder. He had low back pain. The MRI reported in the physician noted degenerative changes (grade I lithesis and L4/5 spinal stenosis).

Dr. saw him as a new physician. There is a comment by a reviewer that he wondered why the man had been dismissed by another physician. This man is on Duragesic, apparently 75 mcg. Dr. wanted to add Lortab qid for the lumbar pain. She wrote that she planned to use the medication and taper him to a prn medication.

He has diabetes.

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

The Reviewer had difficulty understanding the purpose of the Lortab. Hydrocodone is a short acting analgesic usually lasting 3-4 hours. Dr. plans to use it qid presumably to supplement the Duragesic which lasts 72 hours. The Reviewer is not clear if this were for breakthrough pain? If this was end of dose, one would think it would be used every third day. If this was for an increase of pain with a specific activity, then it should be linked to that activity. If this is a constant pain that is relieved by the narcotics, then why not use a larger dose on a fixed schedule. The fact that it is a short acting medication on a fixed schedule is confuses. Even Dr. noted she wanted to taper him from it and then use a prn medication. Without understanding the intent, the Reviewer can not justify its use. He is already on chronic opioid use, so the criteria for initiating care partly apply.

There are multiple sections of the ODG that relate to the topic. The Reviewer took the following relevant sections:

#### **CRITERIA FOR USE OF OPIOIDS**

##### **Therapeutic Trial of Opioids**

**1) Establish a Treatment Plan.** The use of opioids should be part of a treatment plan that is tailored to the patient. ...

Questions to ask prior to starting therapy:

(e) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision....

**4) On-Going Management.** Actions Should Include:...

(c) Office: **Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects.** Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of [function](#), or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. *The 4 A's for Ongoing Monitoring:* Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-

taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. ([Passik, 2000](#))

...

(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion)....

#### 7) When to Continue Opioids

(a) If the patient has returned to work

(b) If the patient has improved functioning and pain

Opioids for chronic pain

#### **Recommendations for general conditions:**

...Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period ( $\leq 70$  days). This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. ([Ballantyne, 2006](#)) ([Furlan, 2006](#)) Long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate (56% in a 2004 meta-analysis). ([Kalso, 2004](#)) There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. ([Martell-Annals, 2007](#)) Current studies suggest that the “upper limit of normal” for opioids prior to evaluation with a pain specialist for the need for possible continuation of treatment, escalation of dose, or possible weaning, is in a range from 120-180 mg morphine equivalents a day. ([Ballantyne, 2006](#)) ([AMDG, 2007](#))

There are several proposed guidelines for the use of opioids for chronic non-malignant pain, but these have not been evaluated in clinical practice, and selection of the patient that will best respond to this treatment modality remains difficult. ([Nicholas, 2006](#)) ([Stein, 2000](#)) One of the most recent of these guidelines is the Agency Medical Director’s Group (AMDG) Guidelines from Washington State. This guideline includes an opioid dosing calculator. ([AMDG, 2007](#))...

Overall treatment suggestions: Current guidelines suggest the following: ...

- The final stage is the maintenance phase. If pain worsens during this phase the differential to evaluate includes disease progression, increased activity, and/or new or increased pre-existing psychosocial factors that influence pain. In addition, the patient may develop hyperalgesia, tolerance, dependence or actual addiction.

([Washington, 2002](#)) ([Colorado, 2002](#)) ([Ontario, 2000](#)) ([VA/DoD, 2003](#)) ([Maddox-AAPM/APS, 1997](#)) ([Wisconsin, 2004](#)) ([Warfield, 2004](#)) See [Substance abuse \(tolerance, dependence, addiction\)](#). See also [Implantable pumps for narcotics](#). See also Opioids in the [Low Back Chapter](#). See [Criteria for Use of Opioids](#).

Opioids, long-term assessment

#### CRITERIA FOR USE OF OPIOIDS

### **Long-term Users of Opioids (6-months or more)**

1) Re-assess

(a) Has the diagnosis changed?

(b) What other medications is the patient taking? Are they effective, producing side effects?

(c) What treatments have been attempted since the use of opioids? Have they been effective? For how long?

**(d) Document pain and [functional improvement](#) and compare to baseline.** Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument.

**(e) Document adverse effects:** constipation, nausea, vomiting, headache, dyspepsia, pruritis, dizziness, fatigue, dry mouth, sweating, hyperalgesia, sexual dysfunction, and sedation.

**(f) Does the patient appear to need a psychological consultation? Issues to examine would include motivation, attitude about pain/work, return-to-work, social life including interpersonal and work-related relationships.**

**(g) Is there indication for a screening instrument for abuse/addiction. See Substance Abuse Screening.**

## **2) Strategy for maintenance**

**(a) Do not attempt to lower the dose if it is working**

**(b) Supplemental doses of break-through medication may be required for incidental pain, end-of-dose pain, and pain that occurs with predictable situations. This can be determined by information that the patient provides from a pain diary or evaluation of additional need for supplemental medication.**

**(c) The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain (Wisconsin)...**

## **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)**