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DATE OF REVIEW:

Apr/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Medication Tramadol, Sertraline, Amitriptyline, Neurontin

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

M.D., Board Certified Orthopedic Surgeon

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

ODG Guidelines and Treatment Guidelines

Office notes, Dr. 03/05/99, 04/29/99, 05/27/99, 11/05/99, 12/17/99, 01/03/00, 01/24/00, 02/14/00, 02/23/00, 03/17/00, 05/16/00, 07/17/00, 01/18/01, 07/17/01, 02/25/02, 08/20/02, 02/17/03, 03/10/03, 09/15/03, 06/08/04, 02/01/05, 07/29/05, 01/26/06, 07/25/06, 01/22/07, 07/23/07, 01/21/08

MRI cervical spine, 04/14/99

Bone scan, 04/14/99

Letter, Dr. 10/16/03, 11/03/03, 05/03/07, 08/14/08, 11/11/08

Peer review, Dr., 03/04/09

Peer review, 03/19/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who was injured on xx-xx-xx. She began treating with Dr. physical medicine and rehab, on 03/05/99. Right wrist x-rays were normal. The claimant had tingling and dysesthesia in the right hand and severe pain in the right wrist in the anatomical snuff box. Wrist range of motion was severely limited. The diagnosis was right wrist strain and right C6 radiculopathy.

MRI of the cervical spine on 04/14/99 showed a posterior disc bulge and posterior osteophytes at C5-6 that produced mild flattening of the spinal cord. There was a central posterior disc bulge at C4-5 that mildly deformed the spinal cord. There was degenerative

loss of disc height from C3-4 thru C6-7. A bone scan on 04/14/99 showed no abnormality about the symptomatic right wrist to suggest occult fracture.

The claimant continued to treat with Dr. She continued to have tenderness and mild swelling in the right wrist and limited range of motion. She had mild pain on extension and rotation of her neck. The right wrist was noted to be cold, swollen and numb on 05/27/99 and the diagnosis of reflex sympathetic dystrophy was given at that time.

On 12/17/99 Dr. placed the claimant on Neurontin. The claimant had pain with cervical extension and rotation to the right and difficulty extending the right wrist. There were no major neurological deficits noted. The diagnosis was right C6 radiculopathy and the physician noted that the claimant was not a surgical candidate. The claimant continued to follow up with Dr. during 2000. As of 2001 she was seeing him every six months. She was taking Neurontin 900 mg three times a day and was placed on Ultram 50 mg 1 or 2 for breakthrough pain. The diagnosis was cervical degenerative disc disease along with reflex sympathetic dystrophy of the right upper extremity. The claimant was placed on permanent work restrictions and was doing an exercise program for the neck, shoulders and right hand.

Visits every six months continued throughout 2002 and 2003. On 02/17/03 Dr. documented continued burning dysesthesia down the right arm. There was tenderness on the right side of the neck with pain on extension and rotation of the neck to the right side. The right wrist on the radial side was exquisitely sensitive to touch. Dr. started the claimant on Zoloft and amitriptyline due to her severe sense of despondency over the chronicity of the injury.

On 09/15/03 Dr. indicated that Neurontin, Ultracet, amitriptyline and Zoloft was necessary to keep the chronic wrist pain tolerable. The claimant was using a wrist brace. Per Dr. office note the claimant had been seen by Dr. and no major abnormalities were found on EMG although he noted that a prior EMG had shown a question of right C6 radicular symptoms. There was no change in exam findings. Dr. indicated that the claimant had an undefined pain syndrome in the right wrist. He felt that a ligament might have been torn in her wrist at the time of the injury and the claimant went on to develop mild reflex sympathetic dystrophy or sympathetic mediated pain. He noted that the claimant was responding well to Neurontin, Ultracet, Amitriptyline and Zoloft.

Dr. authored letters of medical necessity for ongoing use of the medications. It was felt that the claimant had a disc injury at C5-6 and it was felt that much of her symptoms were a chronic regional pain syndrome going down the right arm. The right wrist had significant tenderness and there was a tingling dysesthesia in the C6-7 distribution. There was no change in clinical status or treatment over 2005 and 2006.

On 01/22/07 Dr. noted sympathetic mediated pain to the right upper extremity. The claimant had good cervical range of motion. She was wearing a right wrist splint. She had dystrophic changes over the right hand with limited grip strength and marked decrease in sensation of the entire right hand with a temperature abnormality. Medications were continued. The claimant followed up in 2008 with no change. The claimant remained on Tramadol, Sertraline, amitriptyline and Neurontin for chronic sympathetic mediated pain in the right upper extremity. The above medications were denied as medically necessary on peer review.

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

The reviewer finds that continued use of tramadol, sertraline, amitriptyline, and Neurontin cannot be justified by the medical records reviewed.

The last office note included in the records for this review was from well over a year ago, on 01/21/08. Though sympathetic changes in the right upper extremity were reported, there was no further specific information given regarding physical findings. There is no recent clinical information to document ongoing evidence of a complex regional pain syndrome or sympathetically mediated pain syndrome.

It is not clear that the claimant ever underwent sympathetic blocks, which would be typical treatment for sympathetically mediated pain syndrome. It is not clear that the claimant has undergone prior psychological or psychiatric evaluation, and the antidepressants were reportedly given for a sense of “despondency” rather than for specific treatment of pain. For all of these reasons, the medications cannot be justified based on the information provided for review. More recent clinical information would be required in order to justify ongoing use of these medications. The request does not meet the guidelines. The reviewer finds that medical necessity does not exist for Medication Tramadol, Sertraline, Amitriptyline, Neurontin.

Official Disability Guidelines Treatment in Worker’s Comp 2009 Updates. Pain

Tramadol (Ultram®)

Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic.

Tramadol (Ultram®; Ultram ER®; generic available in immediate release tablet): Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is not classified as a controlled substance by the DEA. Side Effects: Dizziness, nausea, constipation, headache, somnolence, flushing, pruritus, vomiting, insomnia, dry mouth, and diarrhea. Tramadol may increase the risk of seizure especially in patients taking SSRIs, TCAs and other opioids. Do not prescribe to patients that at risk for suicide or addiction. Warning: Tramadol may produce life-threatening serotonin syndrome, in particular when used concomitantly with SSRIs, SNRIs, TCAs, and MAOIs, and triptans or other drugs that may impair serotonin metabolism. Analgesic dose: Tramadol is indicated for moderate to severe pain. The immediate release formulation is recommended at a dose of 50 to 100mg PO every 4 to 6 hours (not to exceed 400mg/day). This dose is recommended after titrating patients up from 100mg/day, with dosing being increased every 3 days as tolerated. For patients in need of immediate pain relief, which outweighs the risk of non-tolerability the initial starting dose, may be 50mg to 100mg every 4 to 6 hours (max 400mg/day). Ultram ER®: Patient currently not on immediate release tramadol should be started at a dose of 100mg once daily. The dose should be titrated upwards by 100mg increments if needed (Max dose 300mg/day). Patients currently on immediate release tramadol, calculate the 24-hour dose of IR and initiate a total daily dose of ER rounded to the next lowest 100mg increment (Max dose 300mg/day). (Product information, Ortho-McNeil 2003) (Lexi-Comp, 2008)

Antidepressants for chronic pain

Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (, 1997) (2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. (2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. (Additional side effects are listed below for each specific drug.) It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants may be undertaken

Gabapentin (Neurontin®, Gabarone™, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain

Anxiety medications in chronic pain

Recommend diagnosing and controlling anxiety as an important part of chronic pain treatment, including treatment with anxiety medications based on specific DSM-IV diagnosis as described below.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)