

I-Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/06/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Reimbursement of out of pocket medication expenses-\$4.00 (unknown) x 2, \$13.40
Zolpidem, \$32.45 Hydrocodone; totalling: \$53.85.

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)

The reviewer finds that medical necessity does not exist for out of pocket medication expenses-\$4.00 (unknown) x 2. The reviewer finds that medical necessity does not exist for \$13.40 Zolpidem. The reviewer finds that medical necessity does exist for \$32.45 Hydrocodone.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Occupational medicine OV 11/21/08, 11/28/08, 12/03/08, 12/12/08, 01/07/09, 01/19/09,

Physical therapy record 12/12/08, 01/19/08

Peer Review 02/09/09

Dr. OV 02/04/09, 03/02/09, 03/25/09, 04/17/09, 05/04/09, 05/18/09, 06/05/09

Dr. DDE 03/02/09

Dr. OV 04/24/09

Dr. OV 06/10/09

Procedure 04/06/09

receipts 08/23/09

Department of Insurance/explanation of benefits.

X-ray Chest 11/21/08, 02/24/09

X-ray KUB 12/24/08

CT abdomen/pelvis 12/29/08

MRI lumbar spine 02/10/09

MRI thoracic spine 02/10/09

EMG/ NCS 02/11/09

X-ray ribs 02/24/09
X-ray left hip 02/24/09
Bone scan 02/24/09
MD request form 03/02/09, 06/05/09
Functional Capacity Evaluation 03/18/09
Functional restoration program 06/24/09
Claimant Questionnaire 02/04/09
Diagnostic testing results and report 03/18/09
Laboratory studies 05/04/09, 04/27/09
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a male claimant with a reported history of low back, rib cage, left hip and shoulder pain as a result of a fall injury on xx/xx/xx. The claimant was diagnosed with a left rib cage contusion, thoracolumbar syndrome, left hip contusion and shoulder sprain/ strain. Post injury headaches were also noted. Physician records of 2008 noted the claimant treated conservatively with medications and light duty. Persistent low back pain, rib cage pain, left hip pain and headaches were noted by the claimant in 2009. Disturbed sleep was also reported. Multiple negative diagnostic studies were reported. Conservative care continued in the form of physical therapy, medications, injection and work restrictions.

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

This is a retrospective case. Dispute was out of pocket medication, one of which was for an unknown medication which I cannot comment on in anyway not knowing what it was, totalling \$4 on two occasions. The reviewer finds that medical necessity does not exist at this time for unknown medication.

The second request was for Ambien (zolpidem), a sleeping agent. This is a short acting; non benzodiazepine hypnotic approved for short term usually 2 to 6 week treatment for insomnia. The extent of treatment was not outlined in the records made available for this review, and thus it cannot be approved. The reviewer finds that medical necessity does not exist for \$13.40 Zolpidem.

The third request was for hydrocodone. The claimant has chronic pain according to the records. There is no contraindication in the use of hydrocodone for chronic pain. The request meets the ODG. The reviewer finds that medical necessity does exist for \$32.45 Hydrocodone.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates

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)