

Notice of Independent Review Decision

DATE OF REVIEW: 07/17/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Oxycontin 60mg 1 tablet po BID #90 no refills

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 anesthesia/pain management with an unrestricted license to practice in the state of Texas. The physician is in active 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 Oxycontin 60mg 1 tablet po BID #90 no refills is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO- 06/30/09
- Notice of determination – 05/27/09, 06/09/09
- Letter from Dr. – 05/20/09, 06/02/09
- Prescription for Oxycontin – 05/20/08, 04/30/09

- Carrier Submission to TMF from attorneys – 07/02/09
- Letter from Dr. – 05/20/09
- Updated peer review by Dr. – 04/23/09
- Peer Review by Dr. – 10/25/09
- Prescription for RS041 sequential stimulator – 08/04/05
- MRI of the Lumbar spine – 09/15/03
- Occupational therapy note – 01/07/03
- Operative Note for facet blocks by Dr. – 11/17/03
- Office visit notes by Dr. – 01/20/04 to 04/07/09
- Required Medical Evaluation by Dr. – 01/19/04
- Nerve conduction study/electromyography – 01/21/04
- Operative reports for facet injections, caudal epiduralgram myelogram, epidural injections and nerve root decompression by Dr. – 02/12/04, 04/08/04, 09/23/04, 01/10/05, 06/16/05, 08/18/05, 09/21/06, 11/16/06, 07/12/07, 10/18/07, 12/13/07, 03/13/08, 06/26/08, 12/09/08, 03/17/09
- Laboratory studies – 02/12/04, 04/08/04, 09/01/04
- Designated Medical Examination by Dr. – 02/25/04
- Psychological Assessment – 05/04/05, 11/07/06
- Psychological Progress Notes – 05/24/05 to 08/09/05
- Portions of hospital record from Medical Center, Admit Dates: – 06/15/05, 06/16/05, 08/18/05, 09/20/06, 09/21/06, 11/15/06, 11/16/06, 05/02/07, 07/11/07, 07/12/07, 10/18/07, 12/12/07, 12/13/07, 03/13/08, 06/25/08
- Prescription refill note for Oxycontin – 10/03/06, 12/01/06
- Prescription for TENS unit – 01/05/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was lifting 40 to 50 lbs of wire and felt pain to his lower back. He has been treated with medication, back brace, TENS unit and at least 15 admissions for epidural injections. The treating physician is requesting approval of a renewed prescription for Oxycontin.

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

The ODG guidelines do not support long term opiates unless there is definite evidence of improved functional status. Copious records were reviewed and there is no documentation of improved function with opiates (Oxycontin). Therefore, there is no indication to continue opiates.

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)