

SENT VIA EMAIL OR FAX ON  
Jun/16/2009

# Applied Resolutions LLC

An Independent Review Organization

1124 N Fielder Rd, #179

Arlington, TX 76012

Phone: (512) 772-1863

Fax: (512) 853-4329

Email: [manager@applied-resolutions.com](mailto:manager@applied-resolutions.com)

**DATE OF REVIEW:**

Jun/15/2009

**IRO CASE #:**

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

Fentora 600mg every 6 hours

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

Board-certified in Internal Medicine.

**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

Denial Letters 5/20/08

5/20/09 and 6/4/09

Health Care 10/9/08 thru 5/26/09

OP Report 12/11/08

Exam 9/23/08

Dr. 1/7/09 thru 4/29/09

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant sustained an injury to the right leg in early xxxx. The exact mechanism of injury is not provided. He had fractures that required fixation. He developed complex regional pain syndrome (CRPS), diagnosed by clinical findings and supported by radiographic studies. A spinal cord stimulator was implanted in December 2008 with some improvement of symptoms. Fentora was initiated in November 2008.

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

The Reviewer has reviewed the applicable guidelines and the peer-reviewed medical literature concerning the use of Fentora in the treatment of CRPS and chronic pain. Fentora is indicated for the management of breakthrough cancer pain in patients who are undergoing treatment with opioid therapy. This medication is not approved or recommended for treatment of musculo-skeletal pain. Although off-label use of Fentora has shown efficacy in

the treatment of musculo-skeletal disorders, within the confines of the ODG Guidelines, its use in this manner cannot be approved.

**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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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