

SENT VIA EMAIL OR FAX ON  
Jun/18/2009

## Pure Resolutions Inc.

An Independent Review Organization

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**DATE OF REVIEW:**

Jun/17/2009

**IRO CASE #:**

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

1. Cialis: 20mg po prior to activity #10;
2. **Phenergan**: 25mg po bid #60;
3. Soma: 350mg po tid #90;
4. Norco: 10/325mg po 4 #180;
5. Visteril: 50mg po tid #90;
6. Neurotin: 900mg po tid #90;
7. Lexapro: 20mg po qd #30;
8. Trazadone: 50mg 1-2 po qhs #60;
9. Dilaudid: 4mg po qid #120 X 1 refill

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC SURGERY

**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)

Soma	Upheld
Phenfren	Upheld
Cialis	Overturned
Dilaudid	Overturned
Norco	Overturned
Vistaril	Overturned
Lexapro	Overturned
Trazadone	Overturned
Neurotonin	Overturned

## INFORMATION PROVIDED TO THE IRO FOR REVIEW

### PATIENT CLINICAL HISTORY SUMMARY

The records provided information of prior problems with drugs and behavior issues. He had been a Vietnam POW. The psychiatric assessment prior to the pump insertion was not available.

This is a man reportedly injured in xxxx when a pipe fell on his right hand. Subsequently, his symptoms spread and he was diagnosed with RSD. The Reviewer does not have this information. This was made initially at where he underwent a reported 32 sympathetic nerve blocks and injections. None of these were provided in the records. He was seen first by Dr. and then by Dr. He had allodynia in the upper and lower extremities, an antalgic gait and cold intolerance reported by these 2 physicians. There were notes of trophic and atrophic changes in 3/22/04, but none were specifically identified. Dr. reported that the pain had "migrated" to include his upper and lower extremities and most of his body. He had a pain pump inserted in 2004 with a revision due to wound healing problems. There was a psychiatric assessment performed, but the Reviewer does not have this. The patient initially reported little benefit from the device until it was no longer filled. The pump was filled quarterly with hydromorphone and bupivacaine, the last being in 11/5/08. He remained with oral medications at that time. The pain reportedly worsened since the pump refills were stopped. Since the last filling of the pump, Dr. reports needing to use oral Dilaudid and hydrocodone to control the pain. Dr. noted that this man was paying his own way for relief since the problems with its approval by the insurance company. He remains on trazadone for sleep, Lexapro for serotonin stores. He is on Cialis. Dr. wrote on 4/26/06 that "The patient has been reporting sexual dysfunction, and reports today that he believes that it is secondary to the pain medications..."

Dr. performed an RME on 6/8/06 by Dr. Dr. did not feel that this man had RSD, but rather some other sort of chronic pain disorder. His impression and diagnosis were based on absence of muscle atrophy normal skin and nails, absence of heat changes, absence of allodynia and hyperpathia, and absence of vasomotor and sudomotor changes. Dr. and Dr. spoke and had different diagnoses. The subsequent treatments had been limited as a result of this RME exam. Medication weaning was also advised. The only examination notes from Dr. describe wide spread allodynia with dysesthesias. His body is "on fire all the time." There was full range of motion.

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

The first issue considered is whether or not this man has a chronic pain condition. That was agreed to by both Dr. and Dr.. The debate over the presence of RSD-CRPD-1 is a factor, but not a final decision maker in this case. As noted "there is no objective gold standard diagnostic criteria. Without being able to establish the diagnosis, the proposed treatment programs RSD would be questionable, but not necessarily for chronic pain. The Reviewer is not being asked whether he has RSD or not, but whether the need for the medications continues.

The ongoing use of opiates for chronic pain remains debated. Some support it. The ODG is generally against the long-term use of opiates, but recognizes that it is necessary. The Medical Board, in Chapter 70, recognizes that there are patients needing controlled medications for benign chronic pain conditions. Chapter 70.3 and the ODG recognize the need for psychological support in people with a history of psychological issues and pain medications. There was no information provided of current abuse or diversion. Dilaudid was used for pain because the pump refill was denied. Should the pump use be resumed, its role will be minimized. Hydrocodone is used for the breakthrough pain. Vistaril, also called Atarax, is justified in the ODG. The same with Lexapro and Trazadone. Soma is not. **Phenergan is often used to control nausea or vomiting. It can, in theory, be used for psychological issues. This was not described in the records. The Reviewer does not recall his having nausea on the pain medications.** Cialis is a special condition that can be open to argument. It is not directly discussed in the ODG. Hypogonadism is and can be a cause of impotence. It can develop from prolonged use of opiates including intrathecal injections. This is present in the case. The mechanism is discussed under the section for testosterone in the ODG. No information was provided in the records to support or refute the presence of any testosterone abnormality. The pain itself and the depression are issues also for ODG. The medications for chronic pain and for RSD pain are discussed in the ODG. The Reviewer agrees with Dr. that the opiates should be reduced, but also recognizes that this is not likely while the man is having pain. It is more likely to be successful once the pain is controlled with the pain pump.

## **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)