



Notice of Independent Review Decision

DATE OF REVIEW: 3/20/09

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for

1. Is ongoing orthopedic or pain man management care necessary and appropriate for this claimant? modified
2. Do you feel the claimant's current medications are appropriate for this injury? (Wellbutrin, tizanidine, tramadol, trazodone, APAP codeine, ketamine, Topamax, Propo-N/APAP.) Please confirm listed prescription medication with claimant. If necessary, please provide a weaning schedule for medications.

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

Texas Licensed Anesthesiologist/Pain Medicine Physician.

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.

The previously denied request for

1. Is ongoing orthopedic or pain man management care necessary and appropriate for this claimant? modified

2. Do you feel the claimant's current medications are appropriate for this injury? (Wellbutrin, tizanidine, tramadol, trazodone, APAP codeine, ketamine, Topamax, Propo-N/APAP.) Please confirm listed prescription medication with the claimant. If necessary, please provide a weaning schedule for medications.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Fax Cover Sheet dated 2/23/09.
- Notice to Assignment of Independent Review Organization dated 2/23/09.
- Notice to CompPartners, INC. of Case Assignment dated 2/23/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 2/23/09.
- Letter dated 2/20/09.
- Request for a Review by an Independent Review Organization Form dated 2/5/09.
- Health Insurance Claim Form dated 2/4/09, 1/5/09, 12/6/08.
- Notification Letter dated 1/13/09.
- Required Medical Evaluation Report dated 1/5/09.
- Explanation of Benefits dated 12/6/08, 11/25/08.
- Letter of Medical Necessity (eligible date).
- Company Request for IRO Information Sheets (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx
Gender: Female Date of
Injury: xx/xx/xx
Mechanism of Injury: Lifting a computer.

Diagnosis: Lumbar spondylosis and chronic low back pain.

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

This female has a history of low back pain since the injury on xx/xx/xx when she was lifting a computer that weighed 10-20 lbs. The patient had a diagnosis of lumbar spondylosis and chronic low back pain. According to the medical note dated 1/5/09, the patient had low back pain that radiated into the right leg and toes. There was associated weakness and decreased sensation in the right leg. On physical examination, there was decreased range of motion (ROM) in the lumbar region. Motor and sensory were normal. Reflexes were normal. Straight leg raising (SLR) test was negative. She was on wellbutrin, lododerm, zanaflex, topamax, trazadoneultram and tylenol #3. The current request is for several things.

1. Orthopedic or pain management care is necessary and the request is modified. As long as the patient is on medications for pain, the patient needs to be seen on a regular basis by pain management, but orthopedic care at this point does not seem necessary. The ODG state, "CRITERIA FOR USE OF OPIOIDS Long-term Users of Opioids (6-months or more) 3) Visit Frequency (a) There is no set visit frequency." This should be adjusted to the patient's need for evaluation of adverse effects, pain status, and appropriate use of medication, with recommended duration between visits from 1 to 6 months.
2. Wellbutrin and Trazodone are non-certified. There was no mention of the patient being depressed and, therefore, this is not needed, as the Physician's Desk Reference, 62nd Edition, states this is used for depression.
3. Tizanidine is non-certified. The ODG state, "Muscle relaxants (for pain) Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP." Tizanidine (Zanaflex®, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain.
4. Ketamine is non-certified. The OSG state, "Ketamine Not recommended." There is insufficient evidence to support the use of ketamine for the treatment of chronic pain. There are no quality studies that support the use of ketamine for chronic pain.
5. Topamax is non-certified. The ODG state "Anti-epilepsy drugs (AEDs) for pain Anti-epilepsy drugs (AEDs) are also referred to as anti-convulsants. Recommended for neuropathic pain (pain due to nerve damage), but not for acute nociceptive pain (including somatic pain). Topiramate (Topamax®, no generic available) has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail." There was no documentation that the patient had failed other anticonvulsants.
6. Tramadol, Propo-n/APAP, APAP codeine are all certified. All 3 are opiopods and can not be stopped as the patient can go into withdrawal, and at this point is on a maintenance dose with good results. The ODG state, "CRITERIA FOR USE OF OPIOIDS, 2) Strategy for maintenance (a) Do not attempt to lower the dose if it is working (b) Supplemental doses of break-through medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. This can be determined by information that the patient provides from a pain diary or evaluation of additional need for supplemental medication. (c) The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain."
7. Please provide a weaning schedule for medications. THERE IS NO NEED FOR WEANING at this point.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
- X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.**
 Official Disability Guidelines (ODG), Treatment Index, 6th Edition (web), 2008,pain chapter-Muscle relaxants,criteria for use of opioids, Anti-epilepsy drugs (AEDs) for pain,Ketamine physicians desk reference 62 edition
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.
- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).
- X OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).**
 Physician’s Desk Reference, 62nd Edition