

SENT VIA EMAIL OR FAX ON
Aug/26/2010

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/25/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

2/10/10-63481068405; 2/23/10-63459070060 and 63857011163; 2/27/10-00093083210;
3/2/10-16714035202; 3/8/10-63481068706
2/10/10 - VOLTAREN
2/23/10 - AMRIX
2/23/10 - FLECTOR
2/27/10 - CLONAZEPAM
3/2/10 - FLUOXETINE
3/8/10 - LIDODERM

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

Board certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics. Medical Director of Rehabilitation.

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)

2/10/10 - VOLTAREN Is medically necessary
2/23/10 - AMRIX Not medically necessary
2/23/10 - FLECTOR Not medically necessary
2/27/10 - CLONAZEPAM Not medically necessary
3/2/10 - FLUOXETINE Is medically necessary
3/8/10 - LIDODERM Not medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Dr. 6/29/01 thru 7/22/10
Dr. 1/29/09
9/14/09

PATIENT CLINICAL HISTORY SUMMARY

This employee was working when she fell. She reported low back pain and radiation down the leg. This was xx/xx/xx. She did have a prior history of back pain that resulted in disectomy and then fusion. She has multiple diagnosis including failed low back syndrome and complex regional pain syndrome, torticollis and sprain/strain of the lumbar spine. She has had an IME by Dr.. She has been maintained on many medications.

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

This patient has chronic pain. The ODG does not recommend topical management of a pain syndrome. Lidoderm patch and flector patch are not appropriate indicated or supported by the ODG or current practice standards. Voltaren is a NSAID. The ODG does recommend NSAID as the first line of treatment in a chronic pain syndrome. This is appropriate. Anti-depressants, such as Fluoxetine, are recommended per the ODG for a chronic pain syndrome. Clonazepam is a benzodiazepine and the long-term use of this medication in chronic pain is not supported by the ODG. Amrix is a muscle relaxant. This is a medication that is not indicated chronically in a condition such as this. If the patient experiences acute spasm or exacerbation of the condition, the Amrix can be prescribed short term.

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)