

# MATUTECH, INC.

PO BOX 310069  
NEW BRAUNFELS, TX 78131  
PHONE: 800-929-9078  
FAX: 800-570-9544

---

## Notice of Independent Review Decision

**DATE OF REVIEW:** December 10, 2010

**IRO CASE #:**

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

Hydrocodone 10/325 mg maximum eight per day as needed, #240 with two refills.

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

Fellow American Academy of Physical Medicine and Rehabilitation  
Member of PASSOR

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Office visits (09/09/99 – 11/02/10)
- Procedure notes (09/23/99 - 05/30/02)
- Laboratory studies (05/09/03 – 04/14/10)
  
- Peer review (07/24/10)
- Office visits (08/05/10 – 11/02/10)
- Utilization reviews (09/02/10, 09/29/10, 11/05/10, 11/22/10)

**TDI**

- Utilization reviews (11/05/10 and 11/22/10)

ODG has been utilized for the denials.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who stepped on tater tots and fell straining her cervical/lumbar areas on xx/xx/xx.

**1998:** No records are available.

**1999 – 2009:** From 1999 through 2009, the patient was seen at Consultants, P.A., by M.D., for left shoulder pain, weakness in the left upper extremity and numbness in the mid back. Examination showed trigger points in the left trapezius, periscapular musculature, pulling sensation in the left trapezius with cervical flexion and left periscapular pain with extension and left Spurling maneuver. Examination of the lower back showed tenderness at the right lumbosacral junction and increased low back pain with extension. Review of a magnetic resonance imaging (MRI) of the cervical spine showed central protrusion at C4-C5 with osteophytes on the left at C4-C5 and facet arthropathy at C5-C6 with left neural foraminal encroachment.

The patient was seen by Dr. for medical evaluation and was recommended an epidural steroid injection (ESI) and chiropractic care. The diagnoses were cervical spondylosis with left C4-C5 and C5-C6 foraminal encroachment producing referred somatic pain in the left periscapular musculature; myofascial syndrome of the left periscapular musculature with trigger points and chronic low back pain secondary to facet arthropathy; sprain of unspecified site of back, neck sprain, high-risk medications and chronic pain syndrome. She was treated with multiple ESIs, trigger point injections (TPI), transcutaneous electrical nerve stimulation (TENS) unit and was prescribed Vicoprofen, baclofen, hydrocodone, Zanaflex, Lidoderm patches, Percocet, Ultram, morphine sulphate, hydrocodone-acetaminophen and OxyContin.

A urine drug screen obtained in October 2009 was negative for opiates and was inconsistent.

**2010:** From February through September, the patient was followed at regular intervals by Dr. who noted upper and lower back pain and pain with Spurling's maneuver. The patient's reported pain level was 4/10 with medications and 10/10 without medications. Dr. maintained the patient on OxyContin, hydrocodone-acetaminophen and Ultram.

Urine drug screens obtained from February through April were positive for benzodiazepines (inconsistent) and opiates (consistent with her medications).

On July 24, 2010, M.D., performed a peer review and rendered the following opinions: (1) In all medical probability, it did not appear that the patient's medications were reasonable and necessary for the work injury. (2) A recent psych evaluation indicated that the patient was at high risk for substance abuse. (3) The drugs prescribed were not within the ODG treatment guidelines or other scientific evidence-based drug guidelines. (4) The patient should be weaned off of OxyContin. (5) An interdisciplinary pain program having emphasis on medication management and/or weaning of substances known for dependence would be appropriate. (6) The drug screening was appropriate and calling the patient in between visits at a time when she should still have prescribed tablets as per the date of prescribing would be appropriate. (7) Pill count monitoring, documentation of all opioids prescribed (even those not paid for by worker's

compensation) and documentation of the number of pills dispensed with each prescription was recommended. (8) If Oxycodone CR was continued an explanation for the necessity of branded product should be given.

Per utilization review dated September 2, 2010, the request for OxyContin 30 mg one p.o. q. 12h., #60 x 30 days and Ultram 50 mg #180 x 30 days one to two p.o. q. 4-6 x 3 refills was denied with following rationale: *"Patient with a 12-year-history of back and neck pain secondary to sprain/strain injury. Recent drug peer review questions need for current medication regimen as it applies to work injury. It is noted: if it is determined that the claimant requires an analgesic, alternative choices to an opioid should be attempted first. This would depend on the diagnosis that is determined. As I have previously noted, the ongoing use of two short-acting opioid analgesics is in all medical probability not recommended as per the ODG. Recent psych eval noted: The overall assessment is that the claimant showed evidence of conversion disorder as well as long-standing psych difficulties. She also appeared to show a high risk for substance abuse. Patient has not been able to return to work. The pharmacy records indicate that claimant has had a recent increase in her tramadol dose (#180 50 mg tablets dispensed on 5/18/10 and 6/2/10. Current request: OxyContin 30 mg: one po Q12 #60 x30 days, Ultram 50 mg #180 x 30 days 1-2 po Q 4-6.)"*

Dr. discontinued OxyContin ER and Ultram and prescribed hydrocodone-acetaminophen 10-325 mg 1-2 tablets every four to six hours #240 with 2 refills. The evaluator noted that hydrocodone was denied. The patient declined Suboxone protocol and stated she would pay for hydrocodone herself.

Per utilization review dated September 29, 2010, hydrocodone 10-325 mg 1-2 Q 4-6 hrs 8/day max #240 with 2 refills was denied with the following rationale: *"A female who had a slip & fall almost 12 years ago with cervical/lumbar strains. She had P.T. and injections (CESI/TPI), last in 2002. She has chronic pain syndrome. She has been on and off hydrocodone virtually the entire time, and at all times on narcotics. Her history since 2007 has been of various combinations of oxycodone, hydrocodone, tramadol, oxycodone ER and morphine ER. Urine drug screen (UDS) of October 2009 not consistent, and UDS of February 2010 not consistent, but allegedly consistent when done in April 2010. Drug peer review in July 2010 noted psych eval that found high risk of substance abuse, and personality/psychological comorbidities. The providers were asked in early September 2010 to wean off OxyContin/Ultram, and recent OV of 9/29/10 indicate those drugs were discontinued. This OV also noted BP of 165/100. It is unclear if medical history, peer review, and psych eval indicate that narcotics are not indicated, why would the provider switch to another high dose narcotic situation?"*

Per utilization review dated November 2, 2010, the request for hydrocodone 10/325 mg max 8/day, p.r.n. #240 with 2 refills was denied with following rationale *"female who had a slip & fall almost 12 years ago with cervical/lumbar strains. She had PT and injections (CESI/TPI), last in 2002. She has chronic pain syndrome. She has been on and off hydrocodone virtually the entire time, and at all times on narcotics. Her history since 2007 has been of various combinations of oxycodone, hydrocodone, tramadol, oxycodone ER, and morphine ER. Urine drug screen (UDS) of October 20'09 not consistent and UDS of February 2010 not consistent, but allegedly consistent when done in April*

2010. Drug peer review in July 2010 noted psych eval that found high risk of substance abuse, and personality/psychological comorbidities. The providers were asked in early September 2010 to wean off OxyContin/ Ultram, and office visit of 9/29/10 indicated that those drugs were discontinued. On 10/5/10 a request was made for hydrocodone. Considering all facts such as the peer review, psyche eval and past inconstant drug screens, the physician advisor did not find that the continuation of the hydrocodone was indicated. A peer /peer discussion was held with P.A. It was agreed that the claimant would be tapered off and started on Suboxone treatment. She agreed to a negotiated approval of only #180 hydrocodone (~6/day), and no refills, and when they revisit in a month, begin Suboxone to keep her off opioids. Office visit of 11/2/10 however indicated that the patient declined this treatment and was going to continue high dose hydrocodone. No recent UDS has been done. At this point I would agree with past decision.” Ms. reported that the patient declined detox and Suboxone and said she was going to pay for med herself. Ms. said the request shouldn't have been submitted for preauthorization.

Per reconsideration review dated November 22, 2010, the request for medication for the cervical and lumbar spine: hydrocodone 10/325 mg maximum of eight per day as needed, #240 with two refills was denied with the following rationale: “The last authorization for this medication was for one refill to accomplish weaning. Also this medication was previously used and found to be of insufficient benefit necessitating an increase in OxyContin. Therefore it is not reasonable and necessary to refill anymore of this medication. Physician Advisor attempted a peer-to-peer phone discussion with Dr. on 11/16/10. Left a message with a call back number and due date/time. Did not receive a return call.”

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

Documentation reviewed indicates prior history of substance abuse. Report of July 2010 noted psych eval that found high risk of substance abuse, and personality/psychological comorbidities .Follow-up psychological assessment indicated ongoing high risk for substance abuse as well. There is no documentation of ODG recommendations of attempted use of non-narcotic analgesics for pain control. There has been no objective measure of functional gains with the use of chronic narcotic use.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**