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Notice of Independent Review Decision

DATE OF REVIEW: 10/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the retrospective medical necessity of Lunesta and Lortab.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 15 years.

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)

The reviewer agrees with the previous adverse determination regarding the retrospective medical necessity of Lunesta. The reviewer disagrees with the previous adverse determination regarding the retrospective medical necessity of Lortab.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr. and.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: progress notes by Dr. 11/16/09 to 7/22/10, 9/17/07 initial patient evaluation report, 8/9/10 LMN, 11/4/09 request for recon letter and 9/8/09 letter by Dr..

: 9/10/10 receipt from pharmacy, 7/22/10 script for Lunesta, 6/30/10 RME report, 9/21/10 EOB, PLN 11 report of 8/16/10, 7/27/10 letter by and 9/2/10 letter by .

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, the patient was injured on xx/xx/xx while at work. Records indicate that he was lifting a file cabinet and fell when the board on which he was standing gave way. He felt a pop and pain in his lower back and pain in the right lower extremity. He underwent evaluation and treatment and surgery was initially offered, but declined. A psychological evaluation was performed demonstrating a somatoform pain disorder. He entered a work hardening program, but was unable to continue with the physical job he was doing at the time of his injury.

MRI studies of the lumbar spine showed central disk herniation at L4-5 and lumbar spondylosis at L5-S1. The patient underwent a L4, L5 right micro hemi laminectomy, discectomy, and foraminotomy on April 5, 2004. This procedure was followed by outpatient physical therapy. In January of 2005, he had an EMG study which demonstrated findings consistent with an L5 radiculopathy.

The patient was diagnosed with a chronic pain syndrome and failed back syndrome and received treatment for many years from Dr.. He began treatment with M.D. on September 17, 2007.

When Dr. initially evaluated the patient, he noted the documented injury and long-term treatment of the chronic pain syndrome. He noted in September of 2007 that the patient was complaining of low back pain with paresthesias in both feet. He was taking Lortab 10 mg ½ to 1 tablet every 6 hours as needed for pain, Ambien CR 12.5 mg at bedtime, and Mobic 1 or 2 as needed for pain.

Dr. noted that the patient had flare-ups of back and right lower extremity pain once or twice every three to four months. These flare-ups were associated with muscle spasms. When present, the back pain interfered with his activities of daily living including household tasks, driving, reaching, lifting, and bending.

Dr. noted that the patient's medical history was significant for hypertension, atrial fibrillation, and a testosterone deficiency.

Dr. initial diagnosis was lumbar degenerative disk disease with herniation, status post decompressive lumbar laminectomy, discectomy, and foraminotomy, and a

chronic pain disorder. Dr. continued the patient's treatment with Lortab, Ambien CR, and Mobic.

Apparently, the patient had a RME during the summer of 2009. The examining physician felt that the patient was experiencing symptoms of nonspecific lower back pain which was a disease of life. Dr., in his rebuttal letter, noted that he was treating the patient for a chronic pain disorder and failed back surgery syndrome, not nonspecific lower back pain.

Dr. has continued to follow the patient and prescribed Lortab for pain, Flexeril for muscle spasms, and most recently Lunesta 2 mg at bedtime because the Ambien CR was not as effective as it was originally.

A second RME was performed on the patient on June 30, 2010 by, M.D. Dr. again reported that his diagnosis was nonspecific lower back pain without evidence of a radiculopathy and he stated that the patient was no longer in need of formal physician re-evaluations and prescription medications.

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

This injured worker had a documented injury to his lower back on xx/xx/xx. MRI studies documented a central disk herniation at L4-5 as well as lumbar spondylosis at L5-S1. He developed chronic low back and right lower extremity pain and received multiple treatments including surgery, physical therapy, and more recently a TENS unit and lumbosacral orthosis. He has been treated with medications including anti-inflammatory drugs, opioids, sleeping medications, and muscle relaxers.

According to physician notes generated from evaluations done approximately every three months, this injured worker has, since the time of his injury, experienced recurrent episodes of incapacitating low back and right lower extremity pain necessitating treatment with opioids, muscle relaxers, and sleeping medications to facilitate restful sleep. Dr. notes indicate that the patient had tried over-the-counter and less potent analgesics, but finds it necessary to take opioids to continue functioning. Records indicate that when the pain is present, it affects his ability to perform household tasks, drive, reach, lift, and bend. Apparently, with the opioids, his symptoms are adequately controlled to allow him to function.

There is a common thread throughout the available medical records that indicates that the patient has a chronic pain syndrome which originated at the time of his injury on xx/xx/xx. The lumbar spondylosis apparently demonstrated by early MRI studies, indicates that there were pre-existing changes of a degenerative nature in the lumbar spine, but the incapacitating back and right lower extremity pain began at the time of his injury and has recurred since its

onset. Therefore, it appears to me that the pain he is experiencing is more than that would be expected from the diseases of normal life and aging and is a residual of his reported injury.

Although ODG Guidelines indicate that opioids should be used for chronic pain when other analgesics are not effective, it appears that the injured worker's physician as well as the injured worker have considered alternative medications and found them to be unacceptable in managing this chronic pain syndrome. The injured worker is being monitored every three months. There is evidence that he is receiving opioids from only one physician and that that physician is monitoring use of the drug closely as described in the ODG Guidelines.

The injured worker meets the guidelines for continued use of opioids, as described in the ODG Guidelines, since he has returned to work within his capabilities as a and he does note improvement in function and pain when he takes the prescribed opioid medication, Lortab. Therefore, the use of Lortab would be medically necessary for management of his chronic pain syndrome.

With regard to Lunesta, Dr. notes indicate sleeping medications have been used for the patient to facilitate restful sleep. These sleeping medications have been used for many years. Secondary insomnia is a recognized comorbid condition in chronic pain. The ODG Guidelines recognize the necessity to use medication for management of acute insomnia. The guidelines also state that sleeping medications should be used in conjunction with cognitive behavioral therapy for chronic insomnia. The ODG Guidelines further state that prescribing medication indefinitely for chronic insomnia will not work. It recommends that cognitive behavioral therapy be combined with medications, but after a few weeks, the recommendation is to discontinue the medication and continue cognitive behavioral therapy. Therefore, at this point, there is no medical necessity for this injured worker to continue to take Lunesta.

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

- ACOEM- AMERICAN 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)