



## Notice of Independent Review Decision

**DATE OF REVIEW:** 11/18/10

**IRO CASE #:**

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

Miscellaneous Medication 09/20/10 through 12/31/10

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

Board Certified in Physical Medicine & 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)

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.

Miscellaneous Medication 09.20.10 through 12.31.10 – UPHELD

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Examination Form, Chiropractic, 08/18/06, 08/21/06, 08/22/06, 08/23/06, 08/25/06, 08/28/06, 08/30/06, 09/01/06, 09/06/06, 09/08/06, 09/11/06, 09/13/06, 09/15/06, 09/18/06, 09/22/06, 09/25/06, 10/02/06, 10/06/06, 10/10/06, 10/13/06, 10/16/06, 10/17/06, 10/20/06, 10/23/06, 10/25/06, 10/27/06, 10/30/06, 11/01/06, 11/03/06, 11/06/06, 11/13/06, 11/19/06, 11/27/06, 12/01/06, 12/04/06, 12/08/06, 12/12/06, 12/13/06, 12/20/06, 12/29/06, 01/19/07, 02/12/07, 02/26/07, 03/12/07, 04/09/07, 04/10/07, 04/23/07, 05/07/07, 05/30/07, 06/11/07, 06/25/07, 07/13/07, 07/27/07
- DWC Form 73, D.C., 08/18/06, 09/11/06, 10/17/06, 10/25/06, 11/01/06, 11/27/06, 12/12/06, 12/13/06, 1/19/07, 03/12/07, 04/10/07
- Evaluation, M.D., 08/21/06, 08/29/06, 09/13/06
- DWC Form 73, Dr. 08/21/06, 08/29/06, 09/13/06
- Evaluation, Rehabilitation Medicine, 08/31/06
- Outpatient Follow Up Visit, M.D., 09/26/06, 09/29/06, 10/16/06
- Lumbar Spine MRI, M.D., 10/21/06
- Initial Behavioral Medical Consultation, M.Ed., 12/15/06
- Behavioral Medical Service Report, Ms., 12/15/06, 05/23/07, 07/10/07, 08/17/07, 09/13/07, 06/29/10
- Consult/History & Physical, M.D., 12/15/06
- DWC Form 73, Dr. 12/15/06, 02/08/07, 03/09/07, 05/23/07, 01/06/10, 04/28/10, 05/26/10
- Orthopedic Consultation, M.D., 01/21/07, 02/02/07, 03/09/07, 04/20/07, 06/20/07
- DWC Form 73, Dr. 01/21/07, 02/02/07, 04/20/07, 06/20/07
- Operative Report, Dr. 01/26/07
- Thoracic Spine X-ray, M.D., 01/26/07
- Progress Note, Dr. 02/08/07, 03/09/07, 05/23/07, 07/10/07, 08/17/07, 09/13/07, 08/25/09, 09/08/09, 04/28/10, 06/15/10, 08/18/10, 09/16/10
- Neurophysiology Laboratory, M.D., 04/17/07
- Operative Report, Dr. 06/29/07, 08/03/07
- Required Medical Evaluation (RME), M.D., 08/16/07
- Correspondence, D.C., 09/18/07
- History & Physical Exam, M.D., 10/23/07
- Peer Review, M.D., 12/21/07, 01/11/08, 02/16/09, 02/22/10, 09/27/10
- Lumbar Epidural Steroid Injection (ESI), Dr. 02/26/10
- Psychodiagnostic Assessment, Ms. 06/29/10
- Denial Letter, 09/23/10, 10/06/10
- Correspondence, P.C., 11/03/10
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient tripped over a tripod while reaching for something on an and injured her back. She underwent chiropractic therapy in 2006 and 2007. She was initially treated with Robaxin 750 mg and Motrin 800 mg. An MRI of the lumbar spine

showed compression fracture of T9 which caused local dorsolumbar kyphosis, increased lumbar lordosis, a small disc herniation at L5, S1 which did not significantly impinge on neural structures and moderate narrowing of the spinal canal at the T9 level. The patient then underwent kyphoplasty at T9. A lumbar ESI was performed, in which she received 50% relief and a second ESI was performed. At that time, she was continued on Norco and Lexapro, adding a Fentanyl patch to her medication regimen. Norco was eventually discontinued, due to ineffectiveness, and Percocet was added.

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

The miscellaneous medication last prescribed by the treating physician, Dr. does not appear to be reasonable and necessary per the ODG Guidelines. The patient is currently receiving Percocet, a short acting narcotic for use in chronic pain as well as Lexapro, which is being used to treat depression. Neither medication is approved for the treatment of low back pain per se, particularly in the chronic phase.

Percocet as a short-acting narcotic is supported by the ODG only for short term use, and any use of long term narcotics would be supported by the ODG only in the presence of improved documented function. The medical notes of Dr. consistently indicate that the patient has pain that is so severe that she is unable to do her home exercise program and that the medication offers very little improvement in symptoms. As such, medical reasonableness and necessity cannot be established.

With respect to the Lexapro, this is an anti-depressant medication prescribed for use primarily in depression. While depression can be a consequence of protracted chronic low back pain, again the ODG would require some documentation of improved function. Dr. indicates that the medication “helps with depression,” but no specific activities of daily living or functional improvements are referenced nor is there any specific diagnostic testing from a psychological basis to evaluate the depression particularly as it relates to functional improvement. Indeed, review of the medical record indicates a long-standing pattern of multiple pharmacologic and procedural interventions in this case in an effort to control symptoms, all of which have consistently failed.

As such, given the significant loss of function documented in this case and lack of improvement with either the Lexapro or Percocet, neither can be established as reasonable and necessary.

**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)**
- AMA GUIDES 5<sup>TH</sup> EDITION**