

# US Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Sep/17/2010

**IRO CASE #: DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Injury Date	Review Type	Date	ICD-9/DSMV	NDC
	Retrospective	8/24/09	722.10	PHARMACY SVCS
	Retrospective	8/24/09	722.10	PHARMACY SVCS
	Retrospective	8/24/09	722.10	PHARMACY SVCS
	Retrospective	9/4/09	722.10	PHARMACY SVCS
	Retrospective	9/4/09	722.10	PHARMACY SVCS
	Retrospective	9/8/09	722.10	PHARMACY SVCS
	Retrospective	9/8/09	722.10	PHARMACY SVCS
	Retrospective	9/15/09	722.10	PHARMACY SVCS

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

MD, Board Certified in Physical Medicine and Rehabilitation and Pain Management

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines and Treatment Guidelines  
Explanation of Benefits, Invoices, Insurance Forms  
Office of Injured Employee Counsel, 7/14/10  
Peer Review, 5/14/09  
DO, 5/14/09

**PATIENT CLINICAL HISTORY SUMMARY**

This patient is a man with an injury date of xx/xx/xx. He was injured while lifting. He was diagnosed by Dr. with a lumbar strain. The MRI dated 1/3/07 showed a disc herniation at L5/S1. There was reportedly a bilateral L4/5 radiculopathy on EMG. A nerve block was performed in June 2007. The patient was found to be at MMI by Dr. on 10/15/07. On 11/25/08, Dr. found L5-S1 spondylolisthesis with instability. Flexion and extension studies showed no subluxation and minimal spondylosis according to the report prepared by Dr. an Orthopedic Surgeon, in 2009. On 5/14/09, Dr. wrote that the diagnostic studies were inconsistent with the pain pattern, and wrote there is "no indication of a pathologic internal

disc disruption.” He wrote that this patient “may have sustained a mild lumbar strain,” and that “he does not have consistent findings that are verified on physical examination.”

His opinion was that there was no indication for further treatment of any kind and that the acute injury of xx/xx/xx had resolved. Magnesium GL Tab 500 MG, Lyrica Cap 50MG, Amitriptylin Tab 50MG, Bupropion Tab 100MG, Compound Component Fee, PLO Base Gel, Ibuprofen POW, Ketoprofen POW, Cyclobenzapr POW HCL, and Lidocaine POW HCL, have been denied as not medically necessary by the insurance company and on peer review.

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

This is a retrospective review for prescription medications including Magnesium GL Tab 500 MG, Lyrica Cap 50MG, Amitriptylin Tab 50MG, Bupropion Tab 100MG, Compound Component Fee, PLO Base Gel, Ibuprofen POW, Ketoprofen POW, Cyclobenzapr POW HCL, and Lidocaine POW HCL. The patient is diagnosed with a mild lumbar strain in. Many of the medications requested for the patient were topical compound medications used for local pain control. According to the records reviewed, there is no medical necessity for these compound medications including Compound Component Fee, PLO Base Gel and Lidocaine POW HCL. According to the ODG, muscle relaxants are recommended as an option in acute cases of moderate to severe LBP. “Muscle relaxants have not been shown to be more effective than NSAIDs. No additional benefit is gained by using muscle relaxants in combination with NSAIDs over using NSAIDs alone.” Based on the ODG, the reviewer finds that there was no medical necessity for Cyclobenzapr POW HCL. The reviewer finds there was no medical necessity for Magnesium GL Tab 500 MG. There was no information provided as to why this was prescribed for this claimant. The reviewer finds there is no medical necessity for Ibuprofen POW, or Ketoprofen POW. According to ODG, “A Cochrane review of the literature on drug relief for low back pain (LBP) suggests that the popular nonsteroidal anti-inflammatory drugs (NSAIDs) are no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics.” The records do not contain any information regarding whether or not this claimant is diagnosed with depression. Therefore, I cannot determine any medical necessity for the use of medications prescribed for depression including. Amitriptylin Tab 50MG, Bupropion Tab 100MG. The reviewer finds that medical necessity does not exist for Lyrica Cap 50MG. There is no evidence in the records of any Diabetic Nerve Pain, Pain after Shingles, or Fibromyalgia in this patient. The reviewer finds that there was no medical necessity for Magnesium GL Tab 500 MG, Lyrica Cap 50MG, Amitriptylin Tab 50MG, Bupropion Tab 100MG, Compound Component Fee, PLO Base Gel, Ibuprofen POW, Ketoprofen POW, Cyclobenzapr POW HCL, and Lidocaine POW HCL.

Injury Date	Review Type	Date	ICD-9/DSMV	NDC	Upheld/Overted
	Retrospective	8/24/09	722.10	PHARMACY SVCS	UPHELD
	Retrospective	8/24/09	722.10	PHARMACY SVCS	UPHELD
	Retrospective	8/24/09	722.10	PHARMACY SVCS	UPHELD
	Retrospective	9/4/09	722.10	PHARMACY SVCS	UPHELD
	Retrospective	9/4/09	722.10	PHARMACY SVCS	UPHELD
	Retrospective	9/8/09	722.10	PHARMACY SVCS	UPHELD
	Retrospective	9/8/09	722.10	PHARMACY SVCS	UPHELD
	Retrospective	9/15/09	722.10	PHARMACY SVCS	UPHELD

**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)