

Core 400 LLC

An Independent Review Organization

209 Finn St

Lakeway, TX 78734

Phone: (512) 772-2865

Fax: (530) 687-8368

Email: manager@core400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Sep/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Oxycodone APAP 10-325 MG

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified in Internal Medicine

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

Adverse Determination, 8/13/10

Network, 3/15/10, 4/20/10

Centers, 12/30/08 - 8/5/10

PATIENT CLINICAL HISTORY SUMMARY

This patient has an established diagnosis of failed back syndrome and complex regional pain syndrome (CRPS) (also known as RSD). She has been treated by Dr. for an extended period of time. His notes demonstrate functional deficits due to pain. She has failed spinal cord stimulator therapy. The provider has requested intrathecal morphine pump in the future, as the patient was having adequate relief from the pump but the pump was "too bulky due to the fact the patient is very small and very skinny." She was prescribed Percocet as needed for pain control on 8/5/10.

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

I have reviewed the ODG concerning the use of opiates in the long-term treatment of failed back surgery syndrome and CRPS. These types of medications are not recommended for routine use as a first-line monotherapy. Opioids may be used as first-line therapy for treatment of acute exacerbations of severe pain. According to the records provided, Percocet has been prescribed on an as needed basis. This is in line with ODG treatment guidelines. While the routine use of this medication is not recommended, the medication is prescribed to this patient only on an as needed basis. Therefore, this prescription is medically necessary as a method to help control her chronic pain. Upon independent review, the reviewer finds that the previous adverse determination should be overturned and that there is a medical necessity for Oxycodone APAP 10-325 MG.

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)