Notice of Independent Review Decision

DATE OF REVIEW: 2/23/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the retrospective medical necessity for reimbursement of $5.41 for Neurontin prescribed by gynecologist.

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 Orthopedic Surgery. The reviewer has been practicing for greater than 10 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 retrospective medical necessity for reimbursement of $5.41 for Neurontin prescribed by gynecologist.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:
The Required Medical Examination revealed that the xx year old was injured in xxxx. She sustained severe neck and back pain. The recent ongoing complaints have been low back and leg pain. She is status post an L3-S1 decompression and fusion in 1992. She is also status post a hardware removal and partial lumbar re-fusion. The claimant has also undergone a cervical fusion. She developed depression. She has been treated overall with multiple medications including Neurontin, in recent years by a pain management provider. The claimant has been noted to have a height of 5’ 8 “and a weight of 250 lbs. The neurological exam revealed no evidence of muscle or sensory deficit with patellar reflexes at 2+ and Achilles reflexes at 3+. Muscle spasm was not evident on examination of the lumbar spine region. The claimant was felt to no longer warrant medical care with regards to the xxxx injury. A 9/9/10 dated Attending Physician letter discussed that the Neurontin was for ongoing

neuropathic pain. The 1/17/11 dated appeal regarding Neurontin related that it was being used for “muscle spasms in my feet” as per the claimant, and, as ordered by her gynecologist. The 2/21/04 dated IME opinion noted that the claimant’s medications (including Neurontin) were at that time all reasonable and for treatment of depression and chronic pain. The 8/26/08 dated IME discussed an indication for ongoing pain management.

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

The claimant’s most recent and overall aggregate of records no longer supports that the claimant has evidence of active radiculopathy, neuropathy or spastic muscles. There has been no documentation that supports that Neurontin has an indication for treatment of depression. Without consistent and ongoing recent evidence of active neuropathy or radiculopathy (as causally related to the date of injury), there is no medically reasonably required indication for the Neurontin prescribed, as per applicable guidelines. In addition, weaning is typically accomplished over a period of weeks at the very least, and, only by an expert in such a field. Therefore, the requested medication is not medically necessary at this time.

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)**