

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/12/2012

**IRO CASE #:**

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

Cymbalta 60 mg 1 p.o. q AM #30; Fentanyl 75mg; Neurotin 400mg 3 p.o. BID #400, Norco 10 1 q4 hours PRN, Baclofen 10 mg 1 PO TID #90 (5 medications)

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

M.D., Board Certified Physical Medicine and 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines  
Request for IRO dated 12/23/11  
Utilization review determination dated 10/31/11  
Utilization review determination dated 11/30/11  
Utilization review determination dated 07/16/10  
Clinical records Dr. dated 03/25/03-present  
Radiographic report chest dated 03/27/03  
CT of head dated 03/27/03  
CT of abdomen dated 03/28/03  
CT of thorax dated 03/28/03  
Procedure report right stellate ganglion block 06/15/03, 08/05/03, 08/19/03, 08/26/03  
Clinical records Dr. 02/04/06  
Procedure report dorsal column stimulator dated 10/28/03  
Clinical records Dr. dated 11/07/03-04/15/04  
Cervical myelogram dated 12/04/03  
Prescription motorized wheelchair dated 03/02/04  
Operative report dated 04/09/04  
Operative report dated 04/15/04  
Radiographic report cervical spine dated 06/30/04  
Procedure report dated 08/11/04  
RME Dr. dated 09/20/04  
Procedure report dated 03/31/05  
IME dated 04/13/05  
Procedure report dated 07/14/05

Procedure report dated 08/04/05  
Procedure report dated 08/18/05  
Procedure report dated 09/01/05  
Procedure report dated 09/15/05  
Thoracic radiographs dated 11/29/05  
Procedure report dated 03/02/06  
Procedure report dated 03/22/06  
Procedure report dated 03/29/06  
Procedure report dated 04/05/06  
Procedure report dated 04/12/06  
Procedure report dated 07/27/06  
Peer review Dr. dated 08/06  
Procedure report dated 10/25/06  
Procedure report dated 11/22/06  
Procedure report dated 01/20/07  
Procedure report dated 03/01/07  
Procedure report dated 02/15/07  
Procedure report dated 05/23/07  
Procedure report dated 07/05/07  
Procedure report dated 09/19/07  
Designated doctor evaluation dated 11/02/07  
Procedure report dated 12/20/07  
Procedure report dated 02/21/08  
Procedure report dated 02/27/08  
Procedure report dated 06/25/08  
Procedure report dated 07/24/08  
Procedure report dated 08/18/08  
Procedure report dated 01/14/09  
Procedure report dated 03/11/09  
Peer review dated 02/08/10  
Operative report dated 03/30/11

#### **PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female who has sustained work related injuries on xx/xx/xx. She is confined to a motorized wheelchair for mobility purposes. She has a diagnosis of reflex sympathetic dystrophy of bilateral upper extremities and bilateral lower extremities. She has undergone extensive treatment to include stellate ganglion blocks to both upper and lower extremities. She is noted to have significant de-conditioning. She clearly has been documented as having chronic pain. The record includes prior IRO determination in which the claimant's use of oral medications was upheld. Dr. follows the claimant for chronic pain management. The initial review was performed by Dr. on 10/31/11 who non-certified the request noting that the clinical records do not document any physical examination data or history taken by the physician. There has not been any documentation of a physical examination for a few months. He further reports that the response to the prior use of the medications including subjective and functional improvement is not known. He notes that baclofen is indicated for the treatment of spasticity and the simultaneous use of topical opiates and oral opioids would be duplications of treatment. He subsequently non-certified the request. Dr. non-certified the request noting that the documentation submitted for review elaborates the patient complaining of ongoing pain related to RSD performed the subsequent appeal request. He notes that Cymbalta per the Official Disability Guidelines is to be used for complaints of anxiety depression and neuropathy however no documentation was submitted regarding the objective efficacy of the ongoing treatment to include range of motion strength or endurance improvement.

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

In excess of 700 pages of records were submitted for review. The records indicate that this claimant has a diagnosis of both upper and lower extremity reflex sympathetic dystrophy. She has received treatment that has included a dorsal column stimulator, a cervical cord

stimulator, stellate ganglion blocks, and chronic use of oral medications. The claimant is largely confined to a motorized wheelchair for ambulation. She very clearly has exceedingly high levels of pain despite all these interventional procedures. The records would indicate that the claimant is stable on her current medication profile. It is clear from the bulk of the records that this claimant is stable on this current profile and that she is being monitored. She has clear evidence of sympathetically mediated pain. The medication profile appears adequate in controlling this. Therefore, the reviewer finds there is a medical necessity for Cymbalta 60 mg 1 p.o. q AM #30; Fentanyl 75mg; Neurotin 400mg 3 p.o. BID #400, Norco 10 1 q4 hours PRN, Baclofen 10 mg 1 PO TID #90 (5 medications).

**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)