

US Resolutions Inc.

An Independent Review Organization

1115 Weeping Willow

Rockport, TX 78382

Phone: (361) 226-1976

Fax: (207) 470-1035

Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/13/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Retroactive Medications

2011-09-14 to 2011-09-14 60 units

2011-09-14 to 2011-09-14 60 units

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

M.D., Board Certified Family Practice

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

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. On the date of injury he is reported to have been xxxxx when he subsequently developed pain in his low back. The claimant was initially evaluated at xxxx by Dr. and diagnosed with lumbar strain. The next several years of records indicate the claimant was treated with oral medications, extensive chiropractic therapy. The records indicate the claimant had multiple surgical consultations and ultimately referred to interventional pain management. He was diagnosed with L5-S1 disc herniation. On 12/28/06 the claimant underwent a lumbar epidural steroid injection. On 01/02/07 the diagnosis of lumbar radiculopathy was confirmed by EMG/NCV study noting findings consistent with right L5 and left S1 radiculopathy. The claimant underwent additional epidural steroid injection on 04/04/07. He later was assessed for work hardening. He was initially given 5% whole person impairment rating. The claimant later came under care of Dr. and underwent a left L5-S1 microdiscectomy on 11/21/07. Postoperatively the claimant is noted to have significant improvement. He reported being 80% better on 12/11/07.

The claimant was evaluated on 01/24/08 and opined to be at maximum medical improvement without impairment. An RME examination on 02/11/08 notes the claimant has made remarkably recovery from surgery and has no symptoms other than minimal 1/10 pain. He reported there is no need for further interventions. The claimant should be weaned off all prescription medications and replaced by OTC drugs. Despite these findings the claimant was ultimately referred for participation in chronic pain management program. He later came under the care of Dr.. The claimant was seen in follow-up for designated doctor evaluation

and was found to be at statutory MMI with 5% whole person impairment. The claimant came under the care of Dr. on 01/12/11. The claimant presents with complaints of low back pain. He is noted to have tenderness at midline and paraspinally. He is reported to have hypertonicity of the paraspinal muscles bilaterally, restriction in range of motion. Straight leg raise produces lumbosacral pain bilaterally. Sensory, motor, and reflexes are intact. He was provided prescriptions for Naprosyn and Flexeril. Serial records indicate the claimant has followed up with Dr. on quarterly basis. He has no overt findings on physical examination other than tenderness and decreased range of motion. He has routinely been provided prescriptions for Flexeril 10 mg 1 po bid #60 and Hydrocodone 5/500 bid #60.

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

The claimant is a male who has history of L5-S1 disc herniation as result of work related activity. The claimant ultimately underwent surgical intervention consisting of L5-S1 microdiscectomy and by all accounts including several designated doctor evaluations, RME, and treating surgeon the claimant had exceptional recovery from this surgery. The claimant presented to Dr. for continued pain management and physical examination is grossly unremarkable. The claimant has myofascial tenderness without evidence of radiculopathy or significant residuals from surgery. There is no data in the clinical record, which would establish medical necessity for continued use of opiate medications or chronic use of muscle relaxant. The current ODG guidelines recommend against chronic use of these medications. Clearly, in absence of residual radiculopathy, there would be no clinical indication for continued use of opiates. Current evidence based guidelines do not support chronic use of muscle relaxants for treatment of myofascial pain. Based on the clinical information provided, the reviewer finds no medical necessity for Retroactive Medications -- 2011-09-14 to 2011-09-14 60 units and 2011-09-14 to 2011-09-14 60 units. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be 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)**