

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/27/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 medication for Right Shoulder / Elbow Injury; Alprazolam Strength .5mg, Quantity 60, refills-0; Days supply: 30 Routine Desc, Oral

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

Board Certified PM&R
Board Certified Pain 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical reports by Dr. MD dated 01/04/11
Clinical reports by Dr. MD dated 05/17/13
Utilization review reports dated 10/04/13 & 11/01/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx when he sustained an injury to the right elbow. No specific mechanism of injury was noted. The patient's prior history has included multiple upper extremity repairs including a right shoulder rotator cuff repair as well as repair of the biceps tendon in xxxx. The patient then underwent a lateral epicondylectomy

in 1999. Further epicondylectomies and rotator cuff repairs were performed in 2008 & in 2009. The last clinical evaluation available for review was from 05/17/13 by Dr. The patient reported a slow increase in the level of his pain with limited use of the right upper extremity. Physical examination demonstrated a negative drop arm test. There was good range of motion reported. No specific measurements were documented. Medications include the use of Voltaren gel on a daily basis. No other recent medications were discussed.

The use of Alprazolam was denied by utilization review on 10/04/13 as there was no documentation regarding anxiety symptoms which would support of the medication.

The medication was again denied by utilization review on 11/01/13 as there were no indications for a Benzodiazepine in the treatment of chronic pain.

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

The patient has been followed for chronic right upper extremity and shoulder complaints. There was no recent assessment documenting continuing use of Alprazolam or documenting any evidence of anxiety conditions which would reasonably benefit from this medication. The clinical documentation does not support the ongoing use of alprazolam. Per current evidence based guidelines, benzodiazepines are not recommended for long-term use as their efficacy is unproven in the relevant clinical literature. At most, benzodiazepines are recommended for short term use only and there is significant risk of developing dependence and abuse with these medications. There is rapid development of tolerance with these medications. Given the lack of any clear evidence that ongoing use of benzodiazepines is effective in this case, it is this reviewer's opinion that medical necessity is not established and the prior denials are 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)