

MAXIMUS Federal Services, Inc.  
4000 IH 35 South, (8th Floor) 850Q  
Austin, TX 78704  
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** January 22, 2013

**IRO CASE #:**

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

Lorcet 10/650, tizanidine 4mg, and piroxicam 20mg.

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

M.D., Board Certified in Orthopedic Surgery.

**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 requested medications, Lorcet 10/650, tizanidine 4mg, and piroxicam 20mg, are not medically necessary for the treatment of this patient.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 12/28/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 1/02/13.
3. Notice of Assignment of Independent Review Organization dated 1/02/13.
4. Denial documentation.
5. Medical records dated 10/27/08, 1/29/09, 4/27/09, 5/26/09, 8/04/09, 11/17/09, 1/14/10, 2/19/10, 4/16/10, 7/15/10, 10/22/10, 1/04/11, 3/07/11, 4/04/11, 4/21/11, 5/09/11, 6/02/11,

- 7/25/11, 8/02/11, 9/01/11, 10/28/11, 12/09/11, 1/23/12, 2/02/12, 3/08/12, 4/18/12, 4/27/12, 6/12/12, 8/16/12, 8/17/12, 9/21/12, 11/05/12, 12/13/12 and undated.
6. Manual muscle strength exam dated 12/09/11, 2/02/12, 4/18/12, 6/01/12, 11/05/12, 12/13/12 and 1/04/13.
  7. CESI operative report dated 6/01/12.
  8. Operative reports dated 11/11/09, 5/19/11 and 1/23/12.
  9. Letter of Medical Necessity dated 10/17/12.
  10. Medical records dated 6/17/09, 2/16/11 and 2/08/12.
  11. Physical therapy notes dated 2/18/10.
  12. Electrodiagnostic interpretation dated 5/18/11.
  13. Lumbar spine MRI dated 4/13/11.
  14. Undated EMG/NCV request form.
  15. Left shoulder MR arthrogram dated 9/17/07 and 4/13/11.
  16. Medical records dated 4/30/08, 4/16/10, 7/15/10 and 10/22/10.
  17. Medical records dated 9/06/07, 4/27/09 and 8/04/09.
  18. Medical records dated 4/18/06, 9/22/06, 11/10/06, 2/21/07, 3/28/07, 7/06/07 and 6/01/12.
  19. Cervical myelogram dated 6/14/07.
  20. Undated Pre-Operative Clearance Order.
  21. MRI of the cervical spine dated 3/29/05.
  22. Medical records dated 1/19/05.
  23. MRI left shoulder dated 12/07/04.
  24. MRI lumbar spine dated 12/07/04.
  25. Medical records dated 9/05/02 and 10/06/04.
  26. MRI of the left shoulder dated 3/24/03.
  27. Cervical spine imaging dated 10/17/02.
  28. Electrodiagnostic report dated 10/16/02.
  29. MRI of the cervical spine dated 8/09/02.
  30. Radiology exam report dated 5/18/02.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who reportedly was injured on xx/xx/xx. On 1/23/12, the patient underwent a lumbar epidural steroid injection with lumbar lysis of adhesions. On 8/16/12, she reported neck pain which radiated to the shoulders and low back pain which radiated to the lower extremities. Per the medical records, physical examination revealed tenderness and decreased range of motion in the cervical spine, with upper extremity weakness and mild paresthesia. She was noted to have a positive impingement sign in the left shoulder. The medical records noted tenderness and decreased range of motion in the lumbar spine, with positive straight leg raise and diminished sensation in the right S1 distribution. On 11/05/12, the documentation noted that the patient was status post a second cervical epidural steroid injection. The patient reported intermittent neck pain, which increased to 5/10 depending on activity. She reported 8/10 low back pain with lower extremity numbness, tingling, and weakness. The patient has requested coverage for Lorcet 10/650, tizanidine 4mg, and piroxicam 20mg.

The URA indicated that the requested medications are not medically necessary. Per the URA, Official Disability Guidelines (ODG) do not recommend the requested medications. On appeal,

the URA indicated that if prescription medications are to be provided on a long-term basis, there must be documentation to indicate the utilization of the prescription medications significantly enhances functional capabilities and/or assists in the ability of an individual to participate in work activities. Per the URA, the records available for review do not provide such data.

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

Official Disability Guidelines (ODG) do not support the medical necessity of the requested medications in this patient's case. The provider has reported that the requested medications are medically necessary for this patient's symptoms. However, the submitted documentation fails to demonstrate significant pain relief or objective functional improvement with the patient's medication regimen. ODG recommend documentation of pain relief, no side effects, and objective functional improvement. All told, the requested Lorcet 10/650, tizanidine 4mg, and piroxicam 20mg are not medically indicated in this clinical setting.

Therefore, I have determined the requested Lorcet 10/650, tizanidine 4mg, and piroxicam 20mg are not medically necessary for treatment of the patient's medical condition.

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**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 JUDGMENT, 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)