

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

Notice of Independent Review Decision

DATE OF REVIEW: January 22, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

OxyContin 20mg, four per day, 120 tablets.

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

M.D., Board Certified in Physical Medicine and Rehabilitation and 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)

I have determined that the requested OxyContin 20mg, four per day, 120 tablets is not medically necessary for the treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 12/30/13.
2. Notice of Assignment of Independent Review Organization dated 1/14/14.
3. Denial documentation.
4. Medical records dated 9/24/12, 12/24/12, 3/20/13, 6/14/13, 8/30/13, 9/19/13, 10/25/13 and 12/16/13.
5. Letter dated 8/30/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with chronic pain. He was seen in clinic on 9/24/12 and stated his back was hurting more than usual. He had chronic low back pain and a burning sensation to his right leg, but overall his symptoms were stated to be stable. The patient had local tenderness to his lumbosacral spine area and had painful and reduced lumbar spine range of motion. Deep tendon reflexes were decreased on the right, motor strength and sensation were decreased in the lateral aspect of both legs, right more than left, and straight leg raise was positive on the right. The provider's assessment was chronic intractable pain. This patient was seen in clinic on 3/20/13, 6/14/13, 8/30/13, 9/19/13, 10/25/13, and returned on 12/16/13 with complaints of chronic pain. The records noted chronic pain with radiation to both legs, right greater than left. Neurologically, he had no focal findings or movement disorder noted. Sensation was decreased on the thighs to both legs and below the knee on the right lateral leg. The provider's assessment was chronic intractable pain, degeneration of the lumbar or lumbosacral intervertebral discs and failed back surgical syndrome. Coverage for OxyContin 20mg, four per day, 120 tablets has been requested.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA noted that the medication dosage is excessive, not appropriate and not medically necessary. On appeal, the URA noted there is no documentation of significant increased function with ongoing use of these medications.

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

Per the submitted documentation, ODG criteria do not support the requested medication in this clinical setting. It was noted that the patient was using OxyContin 40mg, 20mg and 60mg tablets and had a morphine equivalent dose of 360 with a normal recommended morphine equivalent dose of no more than 120. He was also taking roxicodone 5mg, four times a day, which brought his morphine equivalent up to 390. The submitted records indicate this patient has been diagnosed with chronic pain syndrome but do not objectively document his pain with a visual analog scale score. The records do not indicate a current or recent urine drug screen. For patients with chronic pain on high doses of opiates such as in this case, a referral for psychosocial evaluation would also be supported, and a psychosocial evaluation was not provided for this review. Thus, the requested OxyContin 20mg, four per day, 120 tablets is not medically indicated in this patient's case.

Therefore, I have determined the requested OxyContin 20mg, four per day, 120 tablets is not medically necessary for treatment of the patient's medical condition.

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)