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Notice of Independent Review Decision

DATE OF REVIEW: 1/31/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of hydrocodone/APAP 10-500mg, 15 day supply.

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

The reviewer is a Medical Doctor who is 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 reviewer agrees with the previous adverse determination regarding the medical necessity of hydrocodone/APAP 10-500mg, 15 day supply.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source):

Records reviewed:

reports- 11/18/2013, 11/21/2013, 12/26/2013

Reports- 11/210/2013, 12/26/2013

Clinic Report- 11/14/2013

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This male was injured xx/xx/xx, when he was forced to jump off a lift gate to the ground landing on both feet with resultant Right hip pain. When seen November 14, 2013 the patient reported moderate to severe pain being intermittent radiating to the Right leg. The patient reported there was aching and relieved with pain medication and aggravated by activities. Hydrocodone provided less than 50% improvement. On physical examination lumbar spine motion was painful and limited with an antalgic gait noted. Groin pain right hip on palpation with pain on internal rotation. Range of motion significantly reduced right with flexion 60 degrees active and 70 degrees passively, and left hip active 120 degrees, extension 0/0/30, abduction 20/20/45, adduction 20/10/30, external rotation 30/10/45, and internal rotation 10/10/45. The prior peer-reviewed 11/20/2013 recommended non certification of hydrocodone/APAP 10-500 mg noting the history and documentation did not objectively support the hydrocodone requests within ODG recommendation as there was less than 50 % improvement with use of the medication and pattern of use, duration of use, trial of other first line-drugs, pain diary, following with UDS and objective evidence of benefit from the continued use of opioids was not documented. There was no evidence of possible side effects and compliance had been addressed.

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

The prior peer review concerns that there was less than 50 % improvement with use of the medication and pattern of use, duration of use, trial of other first line-drugs, pain diary, following with UDS and objective evidence of benefit from the continued use of opioids was not documented and there was no evidence of possible side effects and compliance having been addressed are still valid. The medical records provided for my review did not contain information addressing the prior peer-reviewed concerns therefore the request for the hydrocodone 10-500mg of 15 day supply is not medically indicated.

V. ODG opioids

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 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)