

# True Decisions Inc.

An Independent Review Organization  
2002 Guadalupe St, Ste A PMB 315  
Austin, TX 78705  
Phone: (512) 879-6332  
Fax: (214) 594-8608  
Email: rm@truedecisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Dec/27/2013

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Oxycontic 60mg, 1 Tablet every 6 hours for Pain (Pill Count: 120 pieces, C refill) related to symptoms of lumbar spine injury

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

Anesthesiologist  
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)

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Clinical record 09/19/13  
Utilization reports 11/04/13 and 11/14/13

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx. The patient was followed for complaints of low back pain. Prior surgical history included rotator cuff repair carpal tunnel release and hernia repair. The patient also underwent prior lumbar laminectomy followed by spinal cord stimulator implantation. The patient was seen on 09/19/13 for ongoing complaints of pain in the lumbar spine rated 5/10 on the VAS with medications and spinal cord stimulator versus 8/10 pain without medications or spinal cord stimulator turned on. Medications at this visit included oxycontin 60mg four times per day and Lyrica, Flexeril, and Restoril. The patient reported an overall 50% pain relief with these medications. The patient denied any adverse effect from these medications. Spinal cord stimulator was placed in March of 2010. Physical examination demonstrated trace to absent reflexes in the lower extremities. Weakness was mild on plantarflexion. There was more profound weakness on dorsiflexion. Sensory deficits were noted in the bilateral L4 through S1 dermatomes. The continued use of oxycontin was denied by utilization review on 11/04/13 as the patient was medically stable with no evidence of an acute neuropathic or neurological condition. The patient was utilizing a high dosage of oxycontin which was a long acting medication. The recommended dosing was at two times per day and the patient was substantially exceeding the manufacturer recommendations for the medication. Oxycontin was again denied by utilization review on

11/14/13 as there was no objective data suggesting the continuation of medication was required other than subjective statements of quality of life. There was no indication that medications changed pain complaints or provided any substantial functional improvement.

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

The patient has been followed for a long history of chronic low back pain following lumbar laminectomy procedures. The patient is utilizing a spinal cord stimulator. Although medications were reported to be effective in controlling pain there is limited clinical documentation establishing the presence of any substantial functional benefit or pain reduction with the continued use of oxycontin that would support its use in this case. The patient is utilizing oxycontin excessively and is exceeding guideline recommendations regarding the maximum amount of narcotics to be utilized in one day. There is no documentation regarding recent compliance testing toxicology results or any recent long term opioid assessments. Given the excessive use of an extended release narcotic above the maximum amount of narcotics recommended in one day per guidelines, and as there is limited evidence regarding ongoing functional benefit or pain reduction with the use of Oxycontin, it is the opinion of this reviewer that medical necessity for this medication is not established. As such 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)