

**Maturus Software Technologies Corporation
DBA Matutech, Inc**

881 Rock Street
New Braunfels, TX 78130
Phone: 800-929-9078
Fax: 800-570-9544

Notice of Independent Review Decision

May 5, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Medication OxyContin 15 mg

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

Diplomate, American Board of 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)

Medical documentation **does not support** the medical necessity of the health
care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who on xx/xx/xx, was reaching a bag when fell on top of
her left foot.

On xx/xx/xx, evaluated the patient for left foot complaints. The patient had
decreased range of motion (ROM) in the foot with flexion and extension. There
was numbness and tingling to the left toe as well as swelling. The patient was
unable to bear weight. Inspection revealed edema over the dorsum of the foot.
There was decreased plantar flexion and dorsiflexion. There was tenderness to
palpation over the dorsum of the foot. X-rays of the left foot showed possible
fracture of the cuneiform and proximal phalanx of the left great toe. diagnosed
crushing injury of the left foot and closed fracture of the left foot; prescribed
Ultracet and recommended using surgical shoe/crutches. The patient was

referred to an orthopedic surgeon. The patient was to elevate the affected limb and apply ice to the affected part.

On February 4, 2008, noted that the overall symptoms had decreased. She discontinued previous medications and added Ultracet. She recommended physical therapy (PT) evaluation and treatment to the left foot.

From February 6, 2008, through March 30, 2008, the patient attended 12 sessions of PT consisting of therapeutic exercises, therapeutic activities, neuromuscular re-education and manual therapy.

On February 12, 2008, noted that overall the patient's symptoms had remained the same. prescribed Arthrotec and continued Ultracet. She recommended continuing PT.

On February 27, 2008, magnetic resonance imaging (MRI) of the left foot showed no specific positive findings.

From March 6, 2008, through March 20, 2008, evaluated the patient for ongoing left foot complaints. She reviewed the MRI findings and recommended continuing PT. The patient was to stop using boot on the left foot. The patient was ordered electromyography (EMG) for persistent pain/swelling and was referred back for persistent swelling and pain. The patient was also referred to an orthopedic surgeon for lower extremity complaints.

On March 26, 2008, evaluated the patient for left foot complaints. The patient was presently on insulin with left mid to forefoot pain and feeling of numbness and tingling. diagnosed crush injury parking spot, diabetes of 14 years' duration, soft tissue contusion, contusion dorsal sensory nerves, anterior tarsal tunnel and questionable small hematoma, second metatarsal. He recommended holding off the PT. The patient was given a full-length boot.

On April 4, 2008, an EMG study was within normal limits for all muscles tested in the bilateral lower extremities. The nerve conduction studies showed low amplitudes bilaterally at the tibial motor, peroneal and sural sensory. H-reflexes were unattainable suggestive of peripheral neuropathy.

From April 16, 2008, through June 30, 2008, continued the patient on PT. The patient was referred to have pain management and possible sympathetic block.

From May 15, 2008, through June 20, 2008, the patient attended rehabilitation program.

From August 19, 2008, through February 4, 2009, treated the patient for ongoing complaints in the left foot. diagnosed complex regional pain syndrome (CRPS), left lower extremity and treated the patient with injection of local anesthetic on sympathetic chain, right L4-L5 segment x3 and radiofrequency lesioning of sympathetic chain, left L4-L5 x1. treated the patient with medications to include

Cymbalta, Lyrica, Vicodin and OxylR. treated the patient for the diagnosis of third neuroma and questionable metatarsalgia with medications to include Naprosyn. had given a removable third metatarsal pad and also a prescription for Shoe Shop.

On February 4, 2009, noted the patient had continued pain in the left foot that was actually better since the procedures, though it had not been able to progress much. The allodynia was better and the hyperesthesia was also better, but the deep pain was not. Evidently, there was a component of neuropathic pain there. discussed spinal cord stimulation (SCS) with the patient.

On February 13, 2009, performed a preoperative psychological evaluation for medication contract and possible SCS trial. Diagnosis was pain disorder with psychological and medical factors and CRPS. Global assessment of functioning (GAF) was 90. The patient's history and clinical interview data was most consistent with the diagnosis of pain disorder with psychological and medical factors. There did not appear to be any indication for psychological treatment presently.

On March 4, 2009, and May 4, 2009, prescribed Cymbalta, Ultram, Neurontin and Vicodin.

On May 12, 2009, performed fluoroscopic-guided identification of the thoracic and lumbar spine, fluoroscopic-guided accessing epidural space at T12-L1, placement of lead in the epidural space, mapping of spinal cord and implantation of electrode for trial of SCS.

From May 15, 2009, through October 23, 2009, treated the patient with medications to include Opana IR, Cymbalta, Neurontin, Norco and Nucynta. The patient was also treated with injection of local anesthetic to sympathetic chain, left L4-L5 x3.

On October 23, 2009, noted that the patient had a temperature aggravation with procedure. There was right thumb swelling and pain. The patient had gone to emergency room (ER), where she had some treatment to include some antibiotics like clindamycin. The patient seemed to have developed that right after the procedure. Even though lumbar sympathetic blocks were performed, her right hand got infected as a coincidence. As it was inappropriate to proceed with injections, referred the patient to an orthopedic hand surgeon, for possible surgical treatment of the swollen thumb which was obviously infected.

On October 23, 2009, obtained x-rays that showed lytic changes in the majority of the distal phalanx, almost down to, but evidently including the interphalangeal (IP) joint. diagnosed probable osteomyelitis secondary to felon or paronychia infection of the right thumb. felt that there was no relationship whatsoever to the low back injections. It would be managed with debridement and probable long-term IV antibiotics.

On October 23, 2009, the patient was admitted for the diagnosis of right thumb osteomyelitis, diabetes, hypertension and gastroesophageal reflux disease (GERD). The patient was seen by infectious disease and plastic surgery. The hospital course was as follows: the patient was started on vancomycin and ceftriaxone and did well. The patient was seen by a plastic surgeon, who felt that the wound was healing appropriately. recommended whirlpool on Monday, Wednesday and Friday three times a week for approximately two weeks. The patient was stable, afebrile during the hospital course. The patient's blood sugars had been slightly elevated given she was taking high-dose insulin; however, she was put back on 65 units in the morning and 30 units at night of lantus. Other home medications were Prevacid, Cymbalta, lisinopril, gabapentin and Vicodin.

On October 23, 2009, evaluated the patient for right thumb osteomyelitis. noted that because of the severity of the pain, the patient finally came to the ER where she had x-rays which suggested osteomyelitis of the right distal phalanx. She had an incision and drainage in the ER. had obtained cultures from the wound, though the wound did have significant drainage. The patient would probably need long-term IV antibiotics and probably empiric at that point. The patient was to continue Rocephin and vancomycin and would need an evaluation by a hand-surgeon.

On October 28, 2009, felt that there was nothing to do with the immune system regarding the bupivacaine injection. denied absolutely 100% and he could define that wholeheartedly that the injection was not the cause of the infection.

On November 9, 2009, prescribed Opana and Vicodin.

On November 10, 2009, noted that the patient was getting whirlpool therapy to the right thumb wound while in the hospital. obtained x-rays of the right thumb that showed clearly mid distal phalangeal bony lysis with some cortical loss. recommended obtaining x-rays in another month and if the patient showed any signs of deterioration of the bone, then potentially she would need a surgical debridement of the distal bony phalanx.

From November 19, 2009, through January 14, 2010, treated the patient with medications to include Opana ER, Vicodin, Cymbalta and Neurontin.

On December 9, 2009, the patient was evaluated by an unknown physician for right thumb complaints. The evaluator felt that the infection had clinically resolved.

On February 11, 2010, evaluated the patient for reflex sympathetic dystrophy (RSD)/complex regional pain syndrome (CRPS), left foot. prescribed Metanx and a trial of compounding cream with ketamine, gabapentin and clonidine to apply b.i.d. to the left foot. The left foot demonstrated asymmetry of color and temperature and atrophic changes involving the skin and nails.

On February 26, 2010, performed an impairment rating (IR) evaluation and assessed clinical maximum medical improvement (MMI) with 11% whole person impairment (WPI) rating.

On March 11, 2010, refilled the medications without changes.

On April 8, 2010, pain management, evaluated the patient for a severe left foot RSD and CRPS. increased Neurontin and recommended a dorsal column stimulator (DCS) implantation.

On May 20, 2010, refilled the medications without changes.

On July 13, 2010, the patient was admitted at the Hospital for complaints of severe excruciating pain of the left lower extremity and low back pain. Diagnosis was left foot ulcer and severe pain. The patient was recommended starting Duramorph IV. The patient was to consult for incision and drainage. The patient was also to consult for infectious disease.

On July 13, 2010, x-rays of the left foot showed questionable abnormality overlying the left medial cuneiform. There was recommendation for a nuclear medicine three-phase bone scan if there was a serious consideration for osteomyelitis.

On July 14, 2010, evaluated the patient for left foot abscess. Diagnosis was recent history with left foot infection, likely an abscess and reaction to cefepime. discussed the case and recommended getting an MRI to determine the extent of infection. The patient was likely to need surgery, excision and drainage. The patient would be switched from cefepime to meropenem and hence Flagyl was discontinued.

On July 15, 2010, MRI of the left lower extremity showed plantar subcutaneous fluid collection which might represent a small superficial abscess. There was mild adjacent soft tissue thickening and enhancement suggesting cellulitis.

On July 15, 2010, performed excisional debridement of left foot diabetic ulcer, Wegner's III.

On July 16, 2010, noted the patient was status post excisional debridement of left foot diabetic ulcer. Intraoperatively, had noted pus draining from the ulcer. would discuss before a final recommended as to the length of antimicrobial therapy. There was no evidence of osteomyelitis by MRI prior to the surgery. The patient seemed to have had reactions to several of the antibiotics. kept the patient on daptomycin and prescribed Levaquin and Flagyl. also came to know that there was an LTAC evaluation order placed.

On January 4, 2011, urine drug screen was positive for hydrocodone and oxycodone. On April 19, 2011, urine drug screen confirmed hydromorphone.

On June 16, 2011, urine drug screen confirmed hydrocodone and hydromorphone.

On July 14, 2011, urine drug screen confirmed oxymorphone, tramadol and o-desmethyl tramadol.

From July 16, 2011, through November 15, 2011, treated the patient for peripheral autonomic neuropathy classified elsewhere with medications to include Norco, Neurontin, and Opana.

On November 15, 2011, urine drug screen was positive for oxymorphone.

On December 13, 2011, urine drug screen was positive for hydrocodone and hydromorphone.

From December 13, 2011, through April 4, 2012, treated the patient with Neurontin, Opana and Norco. Diagnosis was RSD of the lower limb.

On April 4, 2012, urine drug screen was positive for oxycodone.

From May 17, 2012, through July 16, 2012, treated the patient with medications to include Neurontin.

On September 28, 2012, neurosurgeon, evaluated the patient for left leg pain and low back pain. Associated symptoms included weakness, numbness, tingling, stiffness and swelling. The pain was described as sharp, burning, aching, constant, activity related, occurring at rest and occurring at night. Diagnoses were RSD, other specified site and peripheral neuropathy autonomic. prescribed Norco and Opana ER.

On December 6, 2012, a urine drug screen was positive for hydrocodone.

On December 6, 2012, evaluated the patient for left foot pain. There was some swelling noted. The patient described her pain level at 5-6/10. She was taking blood pressure medication. diagnosed RSD, other specified site, chronic pain syndrome and peripheral neuropathy autonomic. prescribed gabapentin and Opana ER.

From January 15, 2013, through April 12, 2013, treated the patient with Nucynta, Norco, gabapentin and Opana ER.

On October 1, 2013, evaluated the patient for left foot pain. The patient rated her pain at 7/10. The patient reported increased pain since the last office visit. prescribed Norco, gabapentin and Nucynta.

On January 29, 2014, evaluated the patient for left foot pain. The pain was described as stabbing, throbbing, sharp, burning pain. The pain level was 7-8/10. There was no new onset of pain or weakness. The patient had moderate allergies

for morphine and clindamycin HCl. Diagnosis was left foot pain, autonomic peripheral neuropathy , RSD, other specified sites; diabetes mellitus type 2, hypertension, ischemic heart disease, dietary surveillance and counseling and body mass index 29.0 to 29.9 adult. prescribed Nucynta ER, Norco, and a topical cream containing gabapentin and Ketoprofen 10%, bupivacaine 2%, DMSO 15%, compound spray, and ketoprofen 10%, cyclobenzaprine 2%, and lido 5%.

On March 3, 2014, a utilization review and denied the request for OxyContin 15 mg based on the following rationale: *“The clinical documentation submitted for review does not meet the guideline recommendations. The Official Disability Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines states four domains have been proposed as the most relevant for ongoing monitoring for chronic pain patients on opiates: Pain relief, side effects, physical and psychosocial functioning and occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. The monitoring of these outcomes overtime should effect therapeutic decisions and provide framework for documentation of the clinical use of control drugs. The patient continued to complain of pain to the foot. However, no clinical documentation was submitted for review showing the efficacy of the pain medications, improved function, side effects or any potentially aberrant drug related behaviors. Also no pain assessment was submitted for review. I discussed the case who indicated the patient was receiving benefit from the medication; however, he was unable to describe any objective improvements. Given the lack of documentation to support guidelines criteria, the request is noncertified.”*

On March 10, 2014, disputed the discontinuation of OxyContin 15 mg. gave prescription for long-acting OxyContin 15 mg one p.o. q. 12h. #60 and a short-acting medication of hydrocodone 10-325 mg one p.o. q. 6h. The patient's pain was of a chronic nature and because of that there was no change in medication regimen for the near future. The patient had tried Opana ER, Nucynta 100 mg and Nucynta 150 mg in the past with no significant pain relief. opined that the medication regimen that the patient was presently on was beneficial and adequate for her chronic condition. The patient was allergic to morphine therefore MS Contin was not an option that could be used in her treatment. requested coverage for that long-term treatment plan until further notice.

Per reconsideration review dated April 1, 2014, denied the appeal for OxyContin 15 mg based on the following rationale: *“The patient is a female with a date of injury in xx/xxxx. The patient has back and left foot pain. She has failed a spinal cord stimulator. She is allergic to morphine sulfate. She has tried Opana and Nucynta. There is no urine drug screen to verify usage. There are other more appropriate medications that are in the formulary. The requested appeal of OxyContin tablet 15 mg is not medically necessary and appropriate.”*

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

There are other medications which are in the formulary which are more appropriate to try than OxyContin 15mg.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES