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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 4/09/15

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Opioid Analgesic: Oxycontin 60mg (#60) Every 12 hours for intractable pain

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

Physician Board Certified in Pain Medicine & Anesthesiology

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overtaken (Disagree) X

Partially Overtaken (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY

This female was injured in xx/xxxx when she sustained a fall. There was a radial spiroid and scaphoid fracture. A right wrist fusion has been performed; also, two cervical fusions: the first at C6-7 and in 2005, C4-5 and C5-6. The patient has been followed by for chronic neck and upper extremity pain. Injections and co-analgesics have been utilized. Her medications include Oxycontin, 60mg, every 12 hours. appeal notes that there is intractable pain and the medications decrease her pain level to an acceptable level and allows her to increase her day to day functional capacity. She has shown no signs of abuse. Urine drug screens have been consistent. Overall, her quality of life has improved with current medications.

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

Opinion: I disagree with the benefit company's decision to deny the requested service.

Rationale: The first reviewer denied the request due to lack of evidence of pain relief, functional gain and appropriate medication use. The absence of side effects mediate any drug taking behaviors. affirmed improvement, comfort, and functionality and stated that there was no evidence of abuse. Drug screens have been consistent. The total dosage concerns have been addressed and ODG are met since there is evidence of improved comfort and functionality and no other options are available. The dosage does exceed the recommended maximum, but this individual is tolerant of medications; she sustained this injury more than 20 years ago and numerous operative and other procedures have been performed. There is no degenerative changes as a result of injury or subsequent surgeries. The dosage of Oxycontin is reasonable given the duration and severity of the injury.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continuation)

Rationale: (continuation)

The reviewer who considered the appeal stated that there was no evidence of functional gain. does

provide evidence of improvement in comfort, function and pain scores. The reviewer also referred to the dosage of medication that exceeds the maximum recommended by ODG. As mentioned above, this individual has had chronic pain for over 20 years and is tolerant of medications. Chapter 170; “*Texas Rules for Physicians*” states that there is no maximum dosage of opioids but the lowest dosage should be utilized that provides a beneficial affect. This is the case with this individual. I recommend approving the Oxycontin, 60mg every 12 hours, as requested. Rationale used: ODG & Chapter 170; “*Texas Rules for Physicians*”.

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & 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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)

*** Texas Medical Board, Chapter 170; “Texas Rules for Physicians”**