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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: August 20, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Oxycodone IR 10mg QID with three refills and hydrocodone 10/325 QID with three refills.

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 with Sub-specialty Certification in 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 oxycodone IR 10mg QID with three refills and hydrocodone 10/325 QID with three refills are not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female with a reported date of injury of xx/xx/xx. The patient is currently being treated for lumbar radiculitis, recurrent left L5-S1 disc herniation, and lumbar disc bulges. Her surgical history was noted to include microdiscectomy at L5-S1 in 2001 and microdiscectomy at L4-5 in 1998. The patient had been prescribed oxycodone IR and hydrocodone since at least 10/23/14. On 7/08/15, the patient continued to have complaints of chronic low back pain. The

records noted that the patient remained stable on the medication regimen. However, it was noted that the patient has been out of oxycodone IR for several weeks. The patient's pain level was rated up to 10/10. On physical examination, the patient demonstrated a very antalgic gait, primarily favoring the left leg. The patient walked in the flexed position, approximately 10 degrees, and could not extend. The patient remained tender over the lumbar region, with a moderate amount of spasms. There were large, well circumscribed trigger points with a positive twitch response at the L4-5 and L5-S1 levels bilaterally. The straight leg raise was positive on the left at 40 degrees and right at 50 degrees. The patient was also noted to have continued left quadriceps weakness and dorsiflexion weakness of the foot, rated 3/5. A request has been submitted for oxycodone IR 10mg QID with three refills and hydrocodone 10/325 QID with three refills.

The URA indicated that the requested medications are not medically necessary. Specifically, the initial denial noted that the requested medications are not medically necessary because it was unclear what the patient's response was to Tylenol #4, as the patient was given a trial of Tylenol #4 on 7/08/15. Further, the clinical documentation did not support multiple refills of these medications. On appeal, the URA noted that the patient has been on multiple medications, although her pain continued to be high. Therefore, the efficacy of the requested medications was in question per the URA.

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

The Official Disability Guidelines (ODG) state that hydrocodone/acetaminophen is indicated for the management of moderate to severe pain in patients who require analgesia for an extended period of time. The guidelines note that patients who are prescribed opiate medications should undergo ongoing review and documentation of pain relief, functional status, appropriate medication and side effects, to include an adequate pain assessment, which should include the current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opiate medication, how long it takes for pain relief to occur, and how long pain relief lasts. Additionally, the guidelines indicate that patients prescribed opiate medications should be seen approximately every 1½ to 2 months to assess the continued efficacy of the medication. Furthermore, the guidelines state that patients prescribed opioid medications should undergo continued review of the overall situation with regard to non-opioid means of pain control. While the provider indicated that the patient's pain had improved at least 50% with the medication regimen, there is no clinical documentation provided that supports this statement. The clinical note on 6/10/15 stated that the patient was stable on her current medications. However, there was no adequate pain assessment provided at that time demonstrating the patient's objective measureable therapeutic benefit with the medication regimen to include objective measureable decrease in pain, measurable increase in function, and approved quality of life. Additionally, while the documentation of 7/08/15 indicated the patient's pain was 10/10 without the use of medication, it was unclear as to what the patient's pain level was with the use of the medication. Furthermore, the prescription for a one month's supply with three refills is excessive and does not allow reassessment of the efficacy of the medication based on the treatment guidelines, which recommends the patient be assessed at 1½ to 2 month intervals. Moreover, there is no documentation in regards to review of pain management with non-opioid

means of pain control. Therefore, the request for oxycodone IR 10mg QID with three refills and hydrocodone 10/325 QID with three refills is not medically necessary.

Therefore, I have determined the requested oxycodone IR 10mg QID with three refills and hydrocodone 10/325 QID with three refills are 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)