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DATE OF REVIEW: 1/30/18

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
OxyContin 30 mg, two by mouth three times per day, #180 for the next two month fills.

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 for OxyContin 30 mg, two by mouth three times per day, #180 for the next two month fills is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XX-year-old XX who was injured in an XXXX on XXXX. The patient reports extreme lumbar and neck pain. The patient has underwent fusion from the occiput to T1. The patient's pain worsened over the past several years. The patient is not able to stand or walk for longer than two minutes. Treatment with epidural steroid injections to the spine have provided the patient the ability to function for almost a year. The patient medications include OxyContin, tizanidine and amitriptyline. Treatment with OxyContin is noted to allow the patient to function and focus as well as move during the day both at home and work. Physical examination, revealed hyperactive lower extremity reflexes due to his spinal cord injury. The patient also has increasingly unsteadiness of the feet. The provider's treatment plan includes OxyContin. The patient is requesting authorization and coverage for OxyContin 30 mg, two by mouth three times per day, #180 for the next two month fills.

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

According to Official Disability Guidelines for chronic pain, opioids should be prescribed at the lowest possible dose to improve pain and function. However, the guidelines states that there must be evidence of functional benefit and a decrease in pain with prior use. There must also be drug monitoring in place. In addition, there should be documentation regarding an objective improvement in pain and function to warrant continued use. There is a lack of documentation regarding an objective improvement in either pain levels or functionality. Furthermore, the documentation submitted for review showed that the previous urine drug screen was performed in XXXX. Therefore, the requested OxyContin 30 mg is not medically necessary for treatment of the patient's medical condition.

Therefore**,** I have determined the requested OxyContin 30 mg, two by mouth three times per day, #180 for the next two month fills is 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)**