ALLMED REVIEW SERVICES INC

jtomsic@allmedreview.com

627 Russell Blvd.

Nacogdoches, TX 75965

936-205-5966 office

(214)802-2150 cell

(888) 272-0749 toll free

(936)205-5967 fax

Notice of Independent Review Decision Revised.

Date notice sent to all parties: 10/26/12 and 10/30/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of chronic pain management program. CPT 97799

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

Texas Licensed Emergency Medicine Physician.

REVIEW OUTCOME:

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

X- Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Review includes:

1. 9/21/12 and 10/3/12 Denial letters.
2. 9/6/12 Behavioral Evaluation
3. 6/28/12 Letter from Dr.
4. 9/26/12 letter of reconsideration
5. 9/6/12 Medical Report from Dr.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx. She was walking down a hall when she slipped on some water. She sustained injuries to her back and head. She was initially taken to Hospital in via ambulance and she was then given some pain medication and then transported to the Hospital Medical Center. She was evaluated there, underwent CT scan of the lumbar spine and she then subsequently followed up with Dr., a neurosurgeon who recommend a lumbar MRI with contrast.

The MRI was performed 02/09/2011 and this showed prior laminectomy and pedicle screws and local stabilization bars at L4-L5 and L5-S1. The canal was widely decompressed. There were flexion and extension films done but there were of some limited views and there was no gross instability.

Dr. recommend an L5-S1 intralumbar interbody fusion with extraction of interbody graft and instrumentation surgery. Pain management doctor Dr. also saw her and he provided medication management.

She was approved for lumbar surgeries by Dr. and this occurred on 11/30/2011 and she was then seen by him on 12/13/2011, staples removed. She was continuing to have lots of pain in her back and was needing more hydrocodone. Because of her continued pain, she was recommended a CT of the lumbar spine; this was done on June 14, 2012, which showed L4-L5 and L5-S1 postsurgical changes,

grade I anterolisthesis L4-L5 and L5-S1. She was recommended for a spinal cord stimulator, but she was wanting a second opinion on that. She was referred to Dr. for a second opinion.

A behavioral assessment was performed on 9/6/12 and the decision was to admit to chronic pain management. This request was denied on appeal based on a supposition that the patient was recommended for additional surgery. The notes only suggest that a second opinion was recommended for spinal cord stimulator.

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

First of all, we will address the rationale for the prior denial. The patient was denied by the appeal physician for possible need of additional surgery. The actual notes suggest there was a referral to Dr. for a second opinion regarding a spinal cord stimulator implantation.

According to the ODG, the patient is currently not a candidate for spinal cord stimulator. The Behavioral Assessment on 9/6/12 revealed chronic pain with psychological factors and depression. Pscyhological clearance is not documented and therefore, a spinal cord stimulator would not be appropriate at this time so the denial based on a pending spinal cord stimulator evaluation is inappropriate.

Regarding the ODG recommendations for a chronic pain program, I do feel this patient would benefit from chronic pain management program. The patient has gotten as far she can, it sounds like with her treating doctors, the behavioral assessment has noted severe problems that are going to need multitask to correct the ODG guidelines. She meets the criteria for the general use of multidisciplinary pain management program and it is considered medically necessary in the following circumstances. The patient has a chronic pain syndrome with evidence of loss of function that persist beyond 3 months and has evidence of three or more of the following:

A. Excessive dependence of health care providers, spouse, or family secondary to physical.

B. Deconditioning due to disuse and/or fear avoidance.

C. Physical activity due to pain, withdrawal from social activities and normal contact with others, including work, recreation, or other social contacts.

D. Failure to restore pre-injury function after a period of disability and physical capacity is insufficient to pursue work, family, or recreational needs.

E. Development of psychosocial sequelae that limits function or recovery after initial incident including anxiety, fear avoidance, depression, sleep disorders, or nonorganic illness behaviors with a reasonable probability to respond treatment intervention as the diagnoses not primarily a personality disorder or psychological condition without any physical component for evidence of continued prescription pain medications to treat those and may result intolerance, dependence or abuse without evidence of improvement in pain or function. Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely result in significant clinical improvement. A multidisciplinary evaluation has been made. Conditions include pertinent diagnostic testing to address the following: Physical exam, evidence of screening evaluation provided when addiction is present or suspected, psychological testing using a validating instrument to identify pertinent areas needed to be addressed.

So, I feel that this patient does meet this criteria, she has had this psychological assessment that shows that she has pain disorder social with both psychological factors and general medical condition and major depressive disorder which is moderate.

IRO REVIEWER REPORT TEMPLATE -WC

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

X-DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

X-MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES