



## Medwork Independent Review

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### *MEDWORK INDEPENDENT REVIEW WC DECISION*

**DATE OF REVIEW:** 03/07/2016

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Pain pump refill.

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

Texas State Licensed MD Board Physical Medicine and Rehab and American Board of 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

### **PATIENT CLINICAL HISTORY:**

The claimant and the previous reviewers did not have documentations submitted for review and as such, there was not enough information to clarify important aspects of continued opioid management, including the pain scores and whether or not, there was abuse, diversion, or misuse of the medication. Since then, the physician has submitted information that would be helpful to continue management. He writes in the facts transmittal dated XX/XX/XX that he is sending a fax request for preauthorization. The claimant has an intrathecal pump that gets refilled every 60 days with morphine 10 mg/mL and that he has attached the copy of the last refill. Included in the documents are the parameters of the pump and that is being used active. Additionally, he has submitted an office evaluate note, detailing important information, including pain scores, which rank 4/10 for the back, 7/10 for the legs, and 7/10 for the feet, and 9/10 at maximum. The claimant is not working, but was used to work as a XX and the mechanism of the injury described as lifting improperly from XX/XXXX. Claimant has had multiple spine surgeries, which is a comensable injury here and appears to what and in part is what the pain pump is being used for. He did have a spinal cord stimulator and the battery failed and has since been unusable.

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



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Psychosocial discussion includes no depression, anxiety, stress, or agitation. A pain diagram reveals axial low back pain with radicular symptoms diffusely into the feet. The patient also signs a controlled-substance agreement that claims he is not abusing prescription drugs or using illicit drugs. There is no evidence of diversion or transport of controlled substances and that there are no major side effects with the narcotics being used. This give enough information, which this documentation, which I suspect was lacking in previous determinations suggest that this claimant is benefitting from the pain pump, as maximum pain scores have reached 9/10 and with the pain pump down to 4/10. The pain pump refill would be approved with the caveat being that documentation in the future be more clear to include functionality while on opioids.

The pump should be filled as it has been routinely to help the patient with pain coverage. Documentation supports that there is no aberrant behavior and that seemingly there is benefit in re: to continued pain relief. It is important to point out that the treating physician has not documented increased functionality with opioid management. This should be addressed on future visits. The lack of this info in itself does not disqualify the patient from receiving needed care, however it should be included in future documentation to adhere to guidelines and what the standard of care in the community considers responsible opioid management.

### **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 JUDGEMENT, 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)