ALLMED REVIEW SERVICES INC

ktomsic@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-Amended

Date notice sent to all parties: 12/4/12 and 12/10/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Please address the medical necessityCPT code 9779, Chronic Pain Management Program 5 days per week for 2 weeks to equal 10 sessions at 80 units

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

Board Certified Physical Medicine and Rehabilitation Physician, licensed in the state of Texas

REVIEW OUTCOME:

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

X	Upheld	(Agree)
☐	Overturned	(Disagree)
☐	Partially Overturned	(Agree in part/Disagree in part)

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:

1. 10/29/12 Reconsideration request
2. Behavioral Evaluation 9/10/12
3. PPE 9/27/12
4. 10/15/12 and 11/12/12 denial letter
5. IRO summary letter dated 11/21/12
6. Chiropractic exams and notes 12/27/11 through 5/10/12
7. EMG/NCV 1/27/12
8. 2/7/12 note

PATIENT CLINICAL HISTORY [SUMMARY]:

sustained a work related injury on *xx/xx/xx* while working. She reports that on the day she was injured she was entering the store when she slipped and fell backwards. The patient reports that she tried to break her fall and landed on her buttocks and arms. The patient states she experienced extreme pain to her lower back, shoulder and left ankle.

She reportedly had received treatment including physical therapy, chiropractic care, and current medications. Official lumbar x-rays and imaging studies are not included for review. Reportedly, the claimant had been recommended to have lumbar epidural steroid injection but it is unclear if she underwent this treatment. Currently, there is a request for a multidisciplinary pain program.

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

Unable to certify the medical necessity and appropriateness of chronic pain program 5 days per week for 2 weeks – 10 sessions at 80 units.

In this case, the claimant has chronic pain but there is little documentation of objective physical examination abnormalities or imaging abnormalities that support serious pathology. There is no systematic approach to evaluation and management of claimant's ongoing symptoms. noted in the medical records reviewed or specific subspecialty evaluations that systematically exclude underlying pathology.

There is little information related to failure to respond to oral medications or any trials of return to work including light duty work or modified work. There is little information related to less intensive chronic pain management strategies which can be performed with intermittent office visit evaluations and follow-up.

There is no information what specific functional impairments are present or why this claimant has

not been able to resolve her chronic symptoms to the point in which she is able to return to work. Consequently, there are incomplete treatment goals noted in the available medical records.

Consequently, the available information does not support the medical necessity and appropriateness of Chronic Pain Management Program 5 days per week for 2 weeks to equal 10 sessions at 80 units.

IRO REVIEWER REPORT TEMPLATE -WC

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 X

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

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

X 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)