

RYCO MedReview

DATE OF REVIEW: 04/10/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Twenty sessions of a chronic pain management program

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

Board Certified in Anesthesiology
Fellowship Trained in Pain Management
Added Qualifications 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)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the thoracic spine interpreted by D.O. dated 06/17/06
Evaluations with D.C. dated 10/02/06, 10/16/06, 10/20/06, 10/30/06, 11/03/06, 12/04/06, 12/15/06, 01/03/07, 01/15/07, 02/12/07, and 02/21/07
DWC-73 forms from Dr. dated 10/02/06 and 02/12/07
An EMG/NCV study interpreted by M.D. dated 10/05/06
An evaluation with M.D. dated 10/23/06
Preauthorization requests from Dr. dated 10/26/06 and 10/30/06
Letters of approval from dated 11/02/06 and 11/10/06

A preauthorization request from Dr. dated 11/03/06
A letter of reconsideration from Billing Department, dated 11/29/06
A procedure note from M.D. dated 11/30/06
A Functional Capacity Evaluation (FCE) with D.C. dated 12/21/06
Evaluations with M.D. dated 01/04/07 and 01/18/07
DWC-73 forms from Dr. dated 01/04/07, 01/18/07, and 02/22/07
A mental health evaluation with L.P.C. and Dr. dated 01/04/07
A preauthorization request from Dr. dated 01/08/07
An evaluation with Dr. dated 01/11/07
Letters of adverse determination dated 01/12/07 and 01/29/07
A request for reconsideration from Dr. dated 01/15/07
An evaluation with D.O. dated 03/06/07
A letter from Dr. dated 02/23/07

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the thoracic spine interpreted by Dr. dated 06/17/06 revealed degenerative changes, a possible partial fusion at T3-T4, and a small disc protrusion at C7-T1. On 10/02/06, Dr. ordered an EMG/NCV study. An EMG/NCV study interpreted by Dr. on 10/05/06 revealed subacute T3 radiculitis and possible mild underlying polyneuropathy. On 10/23/06, Dr. prescribed Tramadol and Flexeril and ordered a cervical epidural steroid injection (ESI). On 10/26/06 and 10/30/06, Dr. provided preauthorization requests for the ESI. On 11/02/06, wrote a letter of approval for the ESI. On 11/03/06, Dr. requested post injection therapy twice a week for three weeks. On 11/10/06, wrote a letter of approval for post injection therapy. A cervical ESI was performed by Dr. on 11/30/06. On 12/21/06, an FCE with Dr. determined the patient functioned at the below sedentary level. On 01/03/07, Dr. recommended a pain management program. On 01/04/07, Ms. and Dr. also recommended the pain management program. On 01/08/07, Dr. provided a preauthorization request for 20 sessions of the pain management program. On 01/12/07 and 01/29/07, provided letters of adverse determination for the pain management program. Dr. provided a reconsideration request on 01/15/07. On 02/21/07, Dr. ordered a thoracic myelogram CT scan. Dr. recommended a facet cervical spine injection on 03/06/07. On 03/23/07, Dr. continued to recommend the pain management program.

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

There is absolutely no medical reason or necessity for this patient to be considered for 20 sessions of a chronic pain management program. It is only appropriate if, and only if, all appropriate medical evaluations and treatment modalities have been exhausted. It is abundantly clear in this case that the patient is still being worked up by Dr. who has requested thoracic myelogram, and by Dr. who is requesting further injection therapy. It

is also abundantly clear based upon the alleged psychological evaluation to determine whether the patient was a candidate for a chronic pain management program that there was, in fact, no evidence of major depressive disorder and, in fact, no evidence of any significant depression whatsoever. Additionally, the patient has never voiced any complaint nor is there any documentation of the patient voicing such a complaint of any depressive symptomatology or psychological issues. Additionally, the patient has had no lesser levels of psychological treatment attempted nor has he even been tried on an appropriate dose of an anti-depressant medication, which, in my opinion, would not even be medically reasonable and necessary based upon the clear lack of evidence of depression on psychological testing. This patient meets no accepted criteria for admission to a chronic pain management program based upon all the records I have reviewed, as he manifests no evidence of psychological illness nor psychological distress has minimal to no objective evidence of any significant pathology, injury, damage, or harm to any part of his body as a result of the alleged work injury, and is clearly still undergoing active medical treatment. Finally, given the clear documentation of the patient's illiteracy, it is highly medically improbable if not entirely unlikely that he would be able to gain any significant benefit from a tertiary care program that relies so strongly upon a patient's ability to interact with and grasp complex psychological issues and treatment modalities. Therefore, for all the above reasons, there is no medical reason or necessity for the requested 20 sessions of a chronic pain management program as related to the alleged work injury.

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**

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)**