

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 08/22/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Twenty sessions five times a week for four weeks of a chronic pain management program (97799-CP)

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.
An MRI of the lumbar spine interpreted by M.D. dated 09/19/05
Evaluations with M.D. dated 12/05/05, 01/09/06, 03/30/06, 06/27/06, 08/08/06, 09/12/06, 11/14/06, 02/13/07, and 07/03/07
Procedure notes from Dr. dated 12/19/05 and 05/17/06

Individualized treatment plans from an unknown provider (no name or signature was available) dated 06/12/06 and 12/05/06

A letter of medical necessity from Dr. dated 11/21/06

Physical Performance Evaluations (PPEs) with O.T.R. dated 12/05/06 and 06/12/07

Evaluations with D.C. dated 12/05/06 and 06/12/07

An evaluation with Dr. (no credentials were listed) dated 05/22/07

Individual therapy with L.M.S.W. dated 06/05/07

A letter of request from Ms. dated 06/12/07

Letters of request from M.D. dated 06/20/07 and 07/18/07

A letter of non-certification from M.D. dated 07/10/07

A letter of appeal from D.O. dated 07/11/07

A letter of non-certification from M.D. dated 07/18/07

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the lumbar spine interpreted by Dr. on 09/19/05 revealed a disc protrusion at L4 and a shallow disc protrusion at L5-S1. On 12/05/05, Dr. recommended an injection, Lyrica, Prilosec, and continued physical therapy. On 01/09/06, Dr. requested a surgical evaluation. A right transforaminal injection at L4-L5 and L5-S1 was performed by Dr. On 03/03/06, Dr. recommended an SI joint injection. The SI joint injection was performed by Dr. on 05/17/06. On 08/08/06, Dr. recommended a CT myelogram. On 09/12/06, Dr. recommended a surgical evaluation. On 11/14/06, Dr. recommended an evaluation with Positive Pain Management. Dr. wrote a letter of medical necessity for a chronic pain management program on 11/21/06. A PPE with Ms. on 12/05/06 indicated the patient was a candidate for 20 sessions of a pain management program. On 12/05/06, Dr. also requested a pain management program. On 02/13/07, Dr. prescribed Lyrica and Protonix. On 05/22/07, Dr. recommended lumbar epidural steroid injections (ESIs) and continued medications. Individual therapy was performed with Ms. on 06/05/07. On 06/12/07, Dr. again requested a pain management program. A PPE with Ms. indicated the patient was a good candidate for the pain management program. On 06/20/07 and 07/18/07, Dr. also requested the pain management program. On 07/10/07, Dr. wrote a letter of non-certification for the pain management program. On 07/11/07, Dr. wrote a letter of appeal for the pain management program. On 07/18/07, Dr. wrote a letter of non-certification for the pain management program.

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

Chronic pain management programs are indicated when all appropriate treatment modalities have been otherwise exhausted. Medical literature also indicates that an initial trial of five days of a chronic pain management program should be approved as a test to determine the patient's compliance and

response to that treatment before completing the subsequent 15 sessions for a total treatment of 20 chronic pain management program sessions. In this case, the patient has clearly not exhausted all appropriate medical treatment options, as it is noted by Dr. on 12/14/06 that the patient was not compliant in going to the physical therapy that was ordered. Additionally, the patient did not gain any clinically significant benefit from six sessions of individual psychotherapy, illustrating the likelihood that the patient would probably not benefit from a psychology-based program. Therefore, since the patient has not exhausted all appropriate treatment options and has already failed to gain clinical benefit from individual psychotherapy, it is not medically reasonable or necessary for this patient to begin twenty sessions of a chronic pain management program. Additionally, based on medical literature, an initial request of 20 sessions of chronic pain management program is not medically reasonable or necessary.

Finally, there is no valid medical diagnosis of depression or anxiety, as the patient has not been evaluated by either a psychiatrist or medical psychologist to justify either of those diagnoses. Analysis of the patient by a licensed social worker or a physical therapist as occurred in the evaluation of this patient for the requested chronic pain management program is neither sufficient nor appropriate for determining the necessity of a tertiary level of care.

Finally, due to the fact that the patient's pain complaint is contralateral to the side of the identified disc bulge on MRI scan, and that contralateral pain is neither physiologic nor organic, it is not reasonable or necessary to treat this patient for such nonorganic, nonphysiologic pain complaints.

Therefore, for all of the reasons cited above, the request for 20 sessions of a chronic pain management program five times a week for four weeks (97799-CP) is not medically reasonable, necessary, or appropriate for treatment of the alleged work injury of therefore, the non-authorization of that program should be upheld.

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)