

August 23, 2007
AMENDED DECISION
Amending decision rendered 04/11/07 in which all
treatment and services in dispute were not considered by
the reviewer for medical necessity.

DATE OF REVIEW: 08/21/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Five (5) individual psychotherapy sessions, twenty (20) sessions of interventional pain management program, and Functional Capacity Evaluation during the period of 05/16/06 through 01/23/07.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology with Certificate of Added Qualifications by the American Board of Anesthesiology in Pain Management

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

There is equivocal evidence to support the medical necessity for the five individual counseling sessions, the twenty sessions of the interventional pain management program, and the Functional Capacity Evaluation.

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
 2. Records review 11/30/05 and EOBs
 3. Medical pre-authorization requests 05/10/06 thru 02/21/07 (8)
 4. Letter of medical necessity and requests for reconsideration 04/20/06 thru 03/22/07
 5. Letter of provider position 02/28/07
 6. History & physical exams 05/18/06 & 02/07/06
 7. Occupation Medicine specialist's evaluations 05/18/ & 07/13/04 and 02/07/06
 8. PPE 11/09/06
-

9. Interdisciplinary pain program session notes 12/04/06 thru 01/05/07 (13 sessions)
10. Individual counseling notes 09/22/06 thru 10/16/06 (5 sessions)
11. Retrospective peer review 02/01/06

SUMMARY OF INJURED EMPLOYEE CLINICAL HISTORY:

This individual is an who sustained a work-related motor vehicle accident on xx/xx/xx. The patient experienced neck and low back pain. Diagnostic studies revealed degenerative changes and a previous cervical fusion. The patient had chiropractic care, medication management, and injections with no improvement. Various Peer Reviews were carried out, and there was an opinion by several reviewers that the patient had conflicting physical findings by various examiners. The collision was minor, and there was no pathology on imaging studies other than degenerative changes that were thought to be pre-existing. There was an opinion that the patient may be malingering.

In spite of these Peer Reviews, the five sessions of psychotherapy were approved by the carrier's representative physician. A multidisciplinary program was also approved for ten sessions and extended for a second ten sessions. Retrospectively, the program along with the psychological testing and Functional Capacity Evaluation were denied as being neither reasonable or necessary.

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

The ODG 10th Edition criteria for the general use of multidisciplinary pain management programs include: (1) an adequate and thorough evaluation; (2) previous methods of treating chronic pain have been unsuccessful; (3) the patient has significant loss of ability to function independently, resulting in chronic pain; (4) the patient is not a candidate where surgery would clearly be warranted; (5) the patient exhibits motivation to change and is willing to forego secondary gains including disability if pain was to affect this change.

This patient meets the first four of these criteria. There are differences of opinion as to whether she met the fifth criteria. Peer Review opinions were that the patient did not meet the fifth criteria, since there was evidence that secondary gain issues were prominent. However, the carrier-designated reviewers were aware of these Guidelines and opined that the criteria were met, and the psychotherapy and chronic pain program were approved.

Retrospective view of the case indicates to me that it is questionable as to whether the fifth criteria was met. Since the carrier's representative opined differently prospectively, it is reasonable and necessary to stand behind that opinion. Therefore, I recommend approving the reimbursement for the psychotherapy sessions, chronic pain management program, and Functional Capacity Evaluation.

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

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).
 - Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
-