



# PROFESSIONAL ASSOCIATES

**DATE OF REVIEW:** 05/21/07

**IRO CASE #:**

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

Twenty sessions of a chronic pain management program (99799-CP)

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

Licensed in Psychology

**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**

MRIs of the cervical and thoracic spines interpreted by an unknown provider (no name or signature was available) dated 03/23/05  
An EMG/NCV study interpreted by M.D. dated 07/21/05  
X-rays of the thoracic and cervical spines interpreted by M.D. dated 09/24/05  
An evaluation with M.D. dated 12/19/05  
An evaluation and operative report from Dr. dated 01/20/06

A discharge summary from Dr. dated 01/22/06  
X-rays of the cervical spine interpreted by M.D. dated 02/27/06 and 05/03/06  
An MRI of the cervical spine interpreted by M.D. dated 06/28/06  
X-rays of the cervical spine interpreted by M.D. dated 07/14/06  
A behavioral evaluation with M.S., L.P.C. dated 11/20/06  
A Functional Capacity Evaluation (FCE) with P.T. dated 12/27/06  
A job description dated 12/27/06  
A Designated Doctor Evaluation with M.D. dated 01/09/07  
A prescription from Dr. dated 01/30/07  
An evaluation with M.S.N. and M.D. dated 02/08/07  
A chronic pain management plan and goals of treatment record from Ms. dated 02/08/07  
A letter of medical necessity from Dr. dated 02/12/07  
A request letter for pain management from M.S., L.P.C. dated 02/15/07  
A letter of denial from Ph.D. dated 02/20/07  
A reconsideration request from Dr. dated 03/13/07  
A reconsideration request from Mr. dated 03/13/07  
A letter of non-certification from Ph.D. dated 03/20/07

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

MRIs of the thoracic and cervical spine interpreted by an unknown provider on 03/23/05 revealed a disc protrusion at C5-C6. An EMG/NCV study interpreted by Dr. on 07/21/05 revealed right C5-C6 nerve root irritation and subacute radiculopathy. X-rays of the cervical and thoracic spine interpreted by Dr. on 09/24/05 revealed early spondylitic change at C5-C6. On 01/20/06, Dr. performed surgery at C5-C6. An MRI of the cervical spine interpreted by Dr. on 06/28/06 revealed the previous surgery. On 11/20/06, Ms. requested a work hardening program. An FCE with Mr. on 12/27/06 revealed the patient functioned at the below sedentary physical demand level and a chronic pain management program was requested. On 01/09/07, Dr. felt the patient was not at Maximum Medical Improvement (MMI). On 02/08/07, Ms. and Dr. also requested a chronic pain management program. On 02/12/07, Dr. wrote a letter of medical necessity for the chronic pain program. On 02/20/07, Dr. wrote a letter of denial for the pain management program. On 03/13/07, Mr. wrote a reconsideration request for the pain program. On 03/20/07, Dr. wrote a letter of denial for the pain program.

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

Based on the records and the medical and psychological evidence provided, a partial approval of 10 days of a chronic pain management program is reasonable and necessary as cited in the ODG Guidelines below. Twenty days are not reasonable and necessary as cited in the same guidelines listed.

“It is recommended they have a trial acceptance and be monitored closely for the first two to five treatment days. Their initial response, compliance, motivation, and understanding of goals can be assessed. If they demonstrate compliance and signs of any initial progress during this trial period, they can continue in the full interdisciplinary treatment with continued review to completion.” (Clinical practice guidelines for chronic non-malignant pain syndrome patients II: An evidence-based approach. Sanders SH, Harden N, Benson SE, Vicente PJ. Clinical practice guidelines for chronic non-malignant pain syndrome patients II: an evidence-based approach. J Back Musculoskeletal Rehabilitation 1999 1; 13; 47-58).

Per the ODG Guidelines, “Treatment is not suggested for longer than two weeks without evidence of demonstrated efficacy as documented by subjective and objective gains.”

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

- (1) An adequate and thorough evaluation has been made.
- (2) Previous methods of treating the chronic pain have been unsuccessful.
- (3) The patient has a significant loss of ability to function independently resulting from the 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 forgo secondary gains, including disability payments to effect this change.

The requesting doctor provides “an adequate and thorough evaluation” that addresses psychosocial factors and treatment goals as well as the appropriate literature cites establishing an adequate rationale for a 10 day trial of a chronic pain program. All lower level care was exhausted including a work hardening program (previous methods of treating the chronic pain have been unsuccessful) and she remains unable to resume work and dependent on opioid medication. The patient exhibits motivation as evidenced by her prior return to work despite chronic pain. The Beck Depression Inventory II and Beck Anxiety Inventory are adequate psychometric tests for screening patients for a chronic pain program.

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

**X ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE**

- 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)**