



DATE OF REVIEW: MAY 31, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program - 10 Sessions

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

Board certified Occupational Medicine, licensed in the State of Texas, and DWC ADL approved.

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)

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Chronic Pain Management – 10 Sessions		Upon approval	Adverse determination upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Record Description	Record Date	Pages
1. Office Visit – Dr. MD	xx/xx/xx	2
2. Lumbar MRI –MRIs	03/15/05	2
3. Shoulder MRI –MRIs	03/15/05	1
4. Office Visit – Dr. DC	03/22/05	1
5. Office Visit – Dr DC	03/28/05	1
6. NCV/EMG –	04/11/05	4
7. Office Visit - Dr. MD	06/22/05	1
8. Office Visit – Dr. DC	08/03/05	1
9. NCV/EMG –	09/15/05	4
10. Cervical MRI –	09/22/05	2
11. Office Visit – Dr. DO	11/08/05	2
12. Left shoulder arthroscopy/decompression report	01/31/06	2
13. Office Visit – Dr MD	02/08/06	1
14. Office Visit – Dr. MD	02/15/06	1
15. Office Visit – Dr. DC	02/20/06	1
16. CT lumbar myelogram –Ctr.	02/21/06	4
17. Office Visit – Dr. MD	03/08/06	1
18. Behavioral Medical Re-Evaluation –LPC	03/13/06	5
19. R. L4-L5 laminectomy / discectomy Operation report – Dr.	03/23/06	2
20. Office Visit – Dr. MD	04/07/06	1
21. Office Visit – Dr. DO	09/11/06	1
22. Office Visit – Dr. DO	11/07/06	2
23. Office Visit – Dr. MD	12/19/06	1
24. Physical Therapy Re-evaluation –PT	02/08/07	7

25. request –LPC	02/09/07	11
26. Preauthorization request for CPMP –	02/09/07	1
27. Office Visit - Dr. MD	02/13/07	1
28. Preauthorization denial letter – IMO	02/15/07	1
29. Physical Therapy Re-evaluation –PT	03/07/07	8
30. Appeal of preauthorization denial –	03/08/07	10
31. Adverse determination of preauthorization appeal	03/16/07	2

PATIENT CLINICAL HISTORY [SUMMARY]:

DOI – x/xx/xx. The patient is s/p left shoulder arthroscopy due to impingement and tendonitis and s/p L4-5 laminectomy/discectomy. Patient noted to have objective signs of lumbar radiculopathy per DDE and was placed in a category III impairment. The patient has completed 20 days of an interdisciplinary pain management program (IPRP) (CPMP) 11/14/06 - 1/19/07 with full compliance and maximal effort documented. Looking at the scores - subjective and objective progress made after 20 days of the IPRP - the gains are minimal AT BEST. BDI and BAI scores are essentially unchanged after 20 days of the CPMP (IPRP). There is a request for an additional 10 visits to the CPMP.

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

Adverse Determination. The gains made in the 20 days of the CPMP completed thus far indicates poor progress both subjectively and objectively, especially from a psychological standpoint. No medical rationale provided why an additional 10 visits is necessitated given such lackluster results thus far. Patient can reasonably be assumed to have received maximal benefit from the CPMP intervention of the 20 visits completed thus far. No reasonable medical anticipation that another 10 visits will make any greater impact than the minimal impact the prior 20 visits have had.

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

ODG 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.
- (3) 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.

INTEGRATIVE SUMMARY REPORTS THAT INCLUDE TREATMENT GOALS, PROGRESS ASSESSMENT AND STAGE OF TREATMENT, MUST BE MADE AVAILABLE UPON REQUEST AND AT LEAST ON A BI-WEEKLY BASIS DURING THE COURSE OF THE TREATMENT PROGRAM. TREATMENT IS NOT SUGGESTED FOR LONGER THAN 2 WEEKS WITHOUT EVIDENCE OF DEMONSTRATED EFFICACY AS DOCUMENTED BY SUBJECTIVE AND OBJECTIVE GAINS.

INPATIENT ADMISSIONS FOR PAIN REHABILITATION MAY BE CONSIDERED MEDICALLY NECESSARY ONLY IF THERE ARE SIGNIFICANT MEDICAL COMPLICATIONS MEETING MEDICAL NECESSITY CRITERIA FOR ACUTE INPATIENT HOSPITALIZATION.
SEE FUNCTIONAL RESTORATION PROGRAMS.

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: the Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 05/01/2007.