

# RYCO MedReview

## Notice of Independent Review Decision

**DATE OF REVIEW:** 11/26/07

**IRO CASE #:**

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

Ten sessions of a chronic pain management program five times a week for two weeks

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

Licensed by the Texas State Board of Chiropractic Examiners

### **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.

Ten sessions of a chronic pain management program five times a week two times a week - Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluations with, M.D. dated 06/12/06, 07/17/06, 08/15/06, and 09/22/06

MRIs of the lumbar spine, thoracic spine, and cervical spine interpreted by., M.D. dated 07/03/06

An EMG/NCV study interpreted by, D.O. dated 07/03/06

Procedure reports from Dr. dated 08/08/06 and 09/12/06

Evaluations with, D.C. dated 11/13/06, 11/14/06, 11/20/06, 11/28/06, 12/11/06, 12/18/06, 12/22/06, 01/08/07, 02/05/07, 03/06/07, 04/12/07, 05/01/07, 05/07/07, 06/26/07, 07/25/07, and 08/20/07

A physical therapy request from Dr. dated 11/13/06

Cervical, thoracic, and lumbar myelogram CT scans interpreted by, M.D. dated 12/06/06

Chiropractic therapy with Dr. dated 01/31/07

An impairment rating evaluation with, M.D. dated 05/30/07

Evaluations with an unknown provider (signature was illegible) dated 05/29/07 and 06/05/07

A psychological evaluation with, L.P.C. dated 07/09/07

Evaluations with, M.D. dated 07/17/07 and 08/21/07

A Functional Capacity Evaluation (FCE) with Dr. dated 07/18/07

A letter of clarification from , Benefits Review Officer, dated 07/18/07

A Designated Doctor Evaluation with, D.O. dated 07/31/07

A preauthorization request from Mr. dated 08/23/07

A letter of non-certification, according to the ODG Guidelines, from, Ph.D. dated 08/29/07

A request for an appeal from an unknown provider (no name or signature was available) dated 09/25/07

A letter of non-certification, according to the ODG Guidelines, from, Ph.D. dated 10/01/07

A letter of preauthorization from, L.V.N. at dated 10/10/07

The ODG Guidelines were not received from the carrier or the URA

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

On xx/xx/xx, Dr. recommended MRIs of the cervical, thoracic, and lumbar spine, physical therapy twice a week for four weeks, and a TENS unit trial. MRIs of the lumbar spine, thoracic spine, and cervical spine interpreted by Dr. on 07/03/06 revealed degenerative disease at L1-S1 with associated mild disc protrusions, mild degenerative endplate spurring at the thoracic spine, and disc protrusions at C4 through C7. An EMG/NCV study interpreted by Dr. on 07/03/06 was normal. Lumbar epidural steroid injections (ESIs) were performed by Dr. on 08/08/06 and 09/12/06. On 09/22/06, Dr. recommended a possible chronic pain program. On 11/13/06, Dr. recommended a CT myelogram and an evaluation with an orthopedic surgeon. Myelogram CT scans of the lumbar, cervical, and thoracic spines interpreted by Dr. on 12/06/06 revealed very mild degenerative changes at L4-L5 and L5-S1, mild disc osteophyte complexes at C5-C6 and C6-C7, and a tiny disc bulge at T7-T8. Chiropractic therapy was performed with Dr. on 01/31/07. On 05/30/07, Dr. placed the claimant at Maximum Medical Improvement (MMI) with a 5% whole person impairment rating. On 07/09/07, Mr recommended a work hardening program. On 07/17/07, Dr. recommended

active physical therapy and Prozac. An FCE with Dr. on 07/18/07 indicated the claimant functioned at a sedentary to sedentary light physical demand level. On 07/31/07, Dr. felt the claimant was not at MMI at that time. On 08/21/07, Dr. recommended a chronic pain management program and continued Prozac. On 08/23/07, Mr. wrote a letter of precertification request for a two week chronic pain management program. On 08/29/07, Dr. wrote a letter of non-certification for the chronic pain management program. On 10/01/07, Dr. t wrote a letter of non-certification for the pain management program. On 10/10/07, Ms. wrote a letter of certification for four sessions of individual counseling.

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

Based upon the medical documentation provided at this time, the medical necessity of a chronic pain management program is not established. This claimant does not meet the criteria for the general use of a multidisciplinary pain management program as set forth by the ODG Pain Chapter Guidelines for chronic pain. The claimant was evaluated on xx/xx/xx by Dr. who determined that the claimant had reached Maximum Medical Improvement as of 05/30/07 with a 5% impairment rating. There was no mention of chronic pain or the medical necessity for a chronic pain program by this physician. On 07/17/07, the claimant was evaluated by Dr.. This physician noted on the physical examination section that the claimant was neurologically alert and oriented x 3. Cranial nerves II through VII are grossly intact, deep tendon reflexes were 2+, and the neck showed normal range of motion in all quadrants (flexion, extension, rotation, and lateral deviation). Straight leg raises are positive at 55° bilaterally with pain radiating to the right lower back. The patient has normal motor and sensory examination and the shoulders show full range of motion. This is a clinical examination that is essentially normal with the exception of a straight leg raise test. The claimant was also assessed by a TDI assigned Designated Doctor on 07/31/07 who noted that the claimant was not at Maximum Medical Improvement and stated that in all likelihood, this claimant would need surgical intervention of his cervical and/or lumbar spines and also recommended injections of the bilateral SI joints and gluteal muscle tendons. The ODG clearly states that the claimant is not a candidate where surgery would clearly be warranted. In addition, there is no mention in the Designated Doctor Report for the medical necessity of a chronic pain management program. At this point, it does not appear that all lower levels of care have been exhausted, particularly at the time that this request was submitted. It is noted that the records document the patient having severe levels of depression and anxiety and this would also be a predictor of failure for a chronic pain management program. Furthermore, it does not appear that any recent attempts have been made to allow the claimant to return to work, be it with or without restrictions. Finally, it is noted that a chronic pain management program essentially deals with irreversible, painful, musculoskeletal, neurological and other chronic painful disorders and psychological issues including drug dependence, high levels of stress and

anxiety, failed surgery, and preexisting or latent psychopathologies. There is no evidence in the medical records provided that this claimant has a drug dependency or that we are dealing with an irreversible, chronic, painful disorder at this juncture. Therefore, in my opinion, the ten sessions of a chronic pain program five times a week for two weeks is neither reasonable nor necessary.

**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)**