



One Sansome Street, Suite 600
 San Francisco, CA 94104-4448
 415.677.2000 Phone
 415.677.2195 Fax
 www.lumetra.com

Notice of Independent Review Decision

DATE OF REVIEW: 09-12-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program (CPMP) x 10 days / sessions

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

Certified by The American Board of Physical Medicine & Rehabilitation
 General Certificate – Physical Medicine & Rehabilitation

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)

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS, CPT, NDC Codes	Service Units	Upheld/Overturn
		Prospective	V45.89	97799	10	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Radiology Report - 03-23-05
 Electromyography (EMG) & Nerve Conduction Study (NCV) Report - 07-21-05

IRO NOTICE OF DECISION - WC

Page 2

Radiology Report - 09-24-05
Medical Notes - 01-20-06
Discharge Summary - 01-22-06
Radiology Report - 02-27-06 to 05-03-06
Radiology Report – 06-28-06
Initial Behavioral Medicine Consultation – 11-20-06
Designated Doctor Evaluation – 01-09-07
Therapy Notes 02-08-07
Letter of Medical Necessity – 02-12-07
Physical Performance Evaluation 07-25-07
Notice of Non-certification Determination – 08-06-07 & 08-21-07
Physician prescription / CPMP Treatment Plan – 01-20-07
Continuation: Request for Additional CPMP – 07-31-07
Reconsideration: Continuation: Request for Additional CPMP – 08-16-07
No ODG Guidelines submitted

PATIENT CLINICAL HISTORY:

The medical records presented for review begin with an MRI report dated March 23, 2005. A small central disk and herniation is noted at the C5-6 level. And electrodiagnostic assessment from July 21, 2005 is noted suggesting a right nerve root irritation at this level.

A thoracic spine and cervical spine radiographs were completed. Early spondylitic changes at the above noted levels were identified. Several months later a cardiology evaluation for back surgery was obtained.

On January 20, 2006 a single-level cervical fusion was undertaken. Subsequent to this surgery plain x-rays noted the fusion and graft to be in place. A repeat MRI of the cervical spine was obtained six months later noting of the surgery and all was relatively normal.

In November a behavioral medicine consultation was obtained and a major depressive disorder was diagnosed.

A Designated Doctor evaluation was completed noting that the claimant was not at maximum medical improvement. A suggested date was May 8, 2007. An evaluation for a chronic pain program was completed in February 2007. This type of program was suggested. It would appear that this program was not pre-certified.

There is a notice of an IRO partially overturning the pre-certification. There was an endorsement for a ten-day trial of this chronic pain program. A summary report noted marginal gains. It does not appear that consideration or continuation of this program was thought to be reasonable required.

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

It is documented in the Official Disability Guidelines that there has to be a reasonable improvement or a success with the traditional treatment protocol to want additional treatments. The gains made were marginal at best and subjective assessments. There was no competent, objective and independently confirmable medical evidence of any reasonable or significant success with this program. Therefore, based on the nationally published literature and the findings reported there does not appear to be any clinical indication for an additional ten days of Chronic Pain Management.

Lumetra's Physician Reviewer has no known conflicts of interest in this case, pursuant to the Insurance Code Article 21.58A (Chapter 4201 effective April 1, 2007), Labor Code § 413.032, and § 12.203 of this title.

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**

IRO NOTICE OF DECISION - WC
Page 4

- 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)**