

# **RYCO MedReview**

## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 09/11/07

**IRO CASE #:**

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

Ten sessions of a chronic pain management program

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

Board Certified in Anesthesiology  
Fellowship Trained in Pain Management  
Added Qualifications in Pain Medicine

### **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 - Upheld

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

Evaluations with, M.D. dated 05/19/06, 06/16/06, 07/19/06, 10/25/06, 01/11/07, and 06/15/07

An evaluation with, M.S., L.P.C. dated 06/06/07

A Physical Performance Evaluation (PPE) with, D.C. dated 06/06/07

A letter of preauthorization request from Mr. dated 06/11/07

Letters of denial dated 06/19/07 and 07/13/07

A letter of denial from, M.D. dated 06/19/07

An appeal letter from Mr. dated 07/03/07

A letter of denial from, M.D. dated 07/13/07

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

On 05/19/06, Dr. recommended a psychological consultation, physical therapy, Ambien, Effexor XR, Morphine, Hydrocodone, Flexeril, and Senna-S. On 07/19/06, Dr.'s recommendations were unchanged except that Celebrex was added to the medications. On 01/11/07, Dr. performed trigger point injections. On 06/06/07, Mr. recommended a chronic pain management program. On 06/11/07, Mr. wrote a letter of preauthorization request for a chronic pain management program. On 06/15/07, Dr. refilled Morphine, Effexor XR, Hydrocodone, Flexeril, Celebrex, Restoril, and Senna-S. On 06/19/07 and 07/13/07, wrote letters of denial for the pain management program. Mr. wrote a letter of appeal for the program on 07/03/07.

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

According to the documentation provided for review and specifically the evaluation performed by Mr. on 06/06/07, it is abundantly clear that this patient has already completed six weeks of a chronic pain management program, which, by her own admission, was not affective in treating her pain. Moreover, despite having completed six weeks of a chronic pain management program, the patient continues to take large amounts of narcotics despite the fact that she is not getting significant clinical benefit or pain relief from those medications. In this case, it is abundantly clear that six weeks of a chronic pain management program have already been tried without clinical benefit and, therefore, repeating a chronic pain management program for any amount of time is not medically reasonable, necessary or indicated. Therefore, the non-authorization of the request for 10 sessions of a chronic pain management program is upheld. There is no support in ODG or any other nationally accepted treatment guidelines for the repeating of ineffective treatment, either.

## **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)