Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 2/4/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The service under dispute is the prospective medical necessity of a 10 session chronic pain management program.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Doctor of Chiropractic with a board certification in Rehabilitation who has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a 10 session chronic pain management program.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
(carrier rep)
(URA)
The totality of records for this case is approximately 12 inches of records.

These records consist of the following (duplicate records are only listed from one source): Mr. 1/18/08 letter, patient computer query results (multiple), 4/13/07to 7/18/07 PLN11 reports, 10/12/07 hearing officer report BRC, 5/21/07 appeal panel decision, 5/21/07 report by, MD, 11/19/07 report, MD, plaintiffs petition

Cause 0614121-E, notes from 12/16/04 to 10/4/05, various TWCC 73s, cervical and lumbar MRI 1/18/05, cervical traction unit, collar and pillow scripts, back brace script by Dr., 1/27/05 pelvic MRI, thoracic MRI of 3/23/05, 2/24/05 note , MD, neurodiagnostic exam of 2/24/05, notes from Dr. 3/9/05 to 3/1/06, Rehab notes 4/18/05 to 5/13/05, 6/14/05 report by MD, operative reports of 7/12/05 to 9/8/05, MD report of 9/30/05, DO 11/3/05 to 12/20/07 reports, 11/4/05 PPE, daily progress notes from Multicare medical 11/7/05 to 12/31/07, reports of 11/10/05 to 12/12/05, 11/17/05 report by MD, FCE 12/2/05 to 3/22/06, reports 2/14/06 to 7/17/07, Case conference notes, 5/16/06 ESI note, notes 5/22/06 to 6/13/06, approval of lumbar surgery note in July 6, 2004, MD report 8/14/06, operative report 8/14/06, post surgical radiology reports of various dates, behavioral medicine eval of 4/5/07, IC session notes 5/3/07 to 5/15/07, 5/7/07 DD report by, MD, cane script, 7/19/07 reports by MD, 7/31/07 lumbar myelogram and post CT and PPE of 10/10/07.

: PM/PT goals dated 10/22/07, a copy of weeks 1 and 2 of the CPM program schedule, 1/10/07 request for review letter by, Ph D, 12/3/07 appeal letter, 10/22/07 preauth letter and 10/15/07 behavioral medicine evaluation (9 pgs).

: no records not previously listed.

We did receive the ODG guidelines for the Chronic pain (400 pages) and lumbar/thoracic spine (413 pages) from the carrier representative.

PATIENT CLINICAL HISTORY [SUMMARY]:

This gentleman was injured on xx/xx/xx while employed with xxxx. An MRI in 2005 indicated bulging at C2/3, C3/4, C4/5 and C6/7. C5/6 had a protrusion with traction spurring and mild foraminal encroachment. The lumbar spine indicated 3mm protrusion at L4/5 and possible annular tear. Neurodiagnostic studies of the same time period indicate no neural findings.

Work hardening was denied according to a note in approximately April of 2006. An ALIF with instrumentation was performed at L4/5 in August of 2006. He was placed at statutory MMI on 12/14/06 with a 15% WP impairment.

He has been treated with multiple modalities and procedures including surgery and has failed to recover to the extent that he indicates he desires.

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

According to the ODG, the criteria for the general use of multidisciplinary pain management programs includes the following: 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, including baseline functional testing so follow-up with the same test can note functional

improvement; (2) Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (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 or other treatments 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; & (6) Negative predictors of success above have been addressed.

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. Total treatment duration should generally not exceed 20 sessions. Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. The patient should be at MMI at the conclusion.
Inpatient pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don't have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. As with outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial rehabilitation with a functional restoration approach.

This patient has met the qualifications for CPM treatment according to ODG for the following: 1) Psych workup indicates this program will benefit the patient.
2) there are no further methods of workup or treatment that are likely to benefit this patient.
3) The patient's independent functioning has been reduced secondary to the disability as a direct result of this injury.
4) No surgical procedures are indicated in the records in the near future.
5) The patient exhibits/indicates motivation to change and reduce his pain levels
6)Negative predictors of success will be addressed in this program.

Therefore, the program is found to be medically necessary for a period of 10 visits over a two week period. Further treatment should be evaluated at that point.

Finally, the ODG states, "Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower grades of CLBP, according to the results of

a prospective longitudinal clinical study reported in the December 15 issue of Spine."

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)**