



# Lumetra

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 07-08-2008

**IRO CASE #:**

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

Fifteen (15) sessions Chronic Pain Management Program (CPMP)

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

Certified by The American Board of Anesthesiology  
Anesthesiology - General  
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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	307.89 727.82 729.5	97799	Upheld

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

Notice of Denial (initial), 05-15-08  
Notice of Denial (reconsideration), 06-09-08  
Mental Health Assessment, 04-04-07  
Psychological Testing and Interpretation, 09-24-07  
Follow Up Visit, 10-11-07, 12-12-07  
Progress notes narrative, 12-04-07 and 01-08-08  
Preauthorization request, 01-30-08  
Evaluation report, 03-27-08  
Functional Capacity Evaluation, 04-07-08  
Weekly Summary Medical, 04-29-08  
Treatment Plan notes, 05-05-08, 05-06-08, and 05-08-08  
Patient information insurance form  
Request for an Appeal: Chronic Pain Management Program  
    Additional 15 sessions, 06-02-08  
Official Disability Guidelines (ODG) Criteria for the general use of  
    multidisciplinary pain management program

## **PATIENT CLINICAL HISTORY:**

The patient is a xx-year-old female with a history of complex regional pain syndrome (CRPS) involving her right upper extremity that resulted from a work related injury. The patient continues to have significant functional impairment. Previous therapies include surgical repair of a torn TFC in February 2007, sympathetic stellate ganglion blockade with no significant response, successful spinal cord stimulator trial with implantation of stimulator unit in February 2008, numerous medication trials and 20 sessions of a chronic pain management program. A request for additional 15 sessions was made.

The provided medical documentation states that, from the previous 20 sessions of the chronic pain management program, the patient's pain has reduced from an 8 to 6 on Visual Analog Scale (VAS). She has increased her performance on the treadmill and stationary bicycle. Her Beck Depression Index (BDI) has decreased from 20 to 11.

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

In the opinion of the Reviewer, based on clinical information provided, the request for 15 additional session of a chronic pain management program is not medically necessary for this patient. In line with the ODG, in reference to chronic pain programs, the total treatment duration should generally not exceed 20 full-day sessions. Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function.

The Reviewer noted that this patient has already completed 20 sessions of a comprehensive pain management program with minimal gains. She has had sufficient formal instruction to be able to employ the techniques that she has been taught on an independent basis.

**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)**