



# Lumetra

Brighter insights. Better healthcare.

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:** 07-09-2008

**IRO CASE #:**

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

30 sessions of

### **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 Management - Subspecialty

### **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	724.2	97799	Upheld

## **PATIENT CLINICAL HISTORY:**

The claimant is a xx-year-old male who sustained a lumbar strain injury on xx/xx/xx while working. Treatments for his low back pain have included physical therapy, chiropractic therapy, medications and interventional procedures. The patient also underwent a L4-5 spinal fusion surgery in 2/2004. He had no change in his symptoms following the surgery. The patient then started and stopped participation in Chronic Pain Management Programs in 7/2004 and 9/2004. He had a FCE on 5/23/08 that placed him at a medium physical demand level. The patient continues to have complaints of high levels of low back pain.

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

In the opinion of the Reviewer the request for 30 sessions of a     is not medically necessary for this patient, based on the clinical documentation provided for review and the Official Disability Guidelines.

The Reviewer noted that per ODG, the criteria for the general use of multidisciplinary pain management programs includes, but is not limited to, the following:

- 1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement. The Reviewer noted that per review of the records provided, a thorough evaluation has not been completed that would allow for comparison to assess the patient's response to therapy.
  
- 2) The patient has a significant loss of ability to function independently resulting from the chronic pain. The Reviewer noted that this patient is currently caring for his son and is able to drive himself around to his appointments. He currently does not display the significant loss of ability to function independently that is required for approval of the requested therapy.

Per ODG, 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 full-day sessions (or equivalent in part-day sessions if required by part-time work, transportation, childcare or comorbidities). 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.

## **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)**