



Specialty Independent Review Organization

## Notice of Independent Review Decision

**DATE OF REVIEW:** 5/14/2008

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a Chronic Pain Management Program 5 times a week for 4 weeks (20 sessions).

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

The reviewer is a medical doctor who is board certified in Physical Medicine and 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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a Chronic Pain Management Program 5 times a week for 4 weeks (20 sessions).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed denial letters-3/11/08 & 4/7/08; Healthcare letter-3/28/08, Work Conditioning/Hardening Weekly Progress report-12/10/07, and Physical Performance Exam-1/3/08.

Records reviewed from MD: Daily Program Progress and Symptom Report and Work Hardening/Conditioning Daily Log-11/7-12/7/07; CPM/WH time sheet-

11/7/7 – 12/7/07; MD Exam Findings-2/5/08; MS, LPC evaluation-9/26/07; DC Functional Abilities Evaluation report-9/19/07.

Records reviewed: Print Claim Notes-7/19/07 – 4/29/08; DWC 1-7/19/07; various DWC73s; Services MMI Benefit Payment letter-3/12/08; DWC69-2/15/08; MD DDE report-2/15/08; MD Retrospective Peer Review-2/20/08; Request for Designated Doctor-1/10/08; MD report-8/28/07; denial letters-7/27/07, 8/17/07, & 8/24/07; and DO report-7/26/07.

While the ODG was referenced in the URA denial letters, a copy of the ODG was not provided for this review.

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

The patient was injured when falling on the job sustaining a right shoulder injury. A right shoulder MRI verified a full thickness cuff tear. She was managed with subacromial injection, oral analgesics, NSAID, PT x 20 visits, and work hardening. Surgical intervention was offered and declined by the patient.

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

The reviewer states that according to the ODG “Criteria for the general use of multidisciplinary pain management programs:

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.” This is documented by, MD., LPC on 9/26/07, upon entry into Work Hardening. Secondary anxiety and depression have been identified, but there is no documentation of the prescription of any appropriate medication or therapy to assist the patient with these issues prior to trial of a comprehensive chronic pain management program.

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.

As the patient has not met the criteria for a multi-disciplinary pain management program the is not medically necessary according to the ODG.

**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)**