



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 05/28/08 (AMENDED 06/02/08)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten sessions of a chronic pain management program (97799)

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 (97799) - Upheld

PATIENT CLINICAL HISTORY

This patient was allegedly injured on xx/xx/xx in a slip-and-fall injury at work. She was initially evaluated on 06/03/07 by Dr. who stated that the patient fell at work, hit the back of her head, and complained of pain in the right anterior shin, right low back, posterior neck, and the back of her neck. Physical examination by Dr. documented non-specific tenderness at the back of the head, normal neurological examination, non-specific tenderness of the entire lumbar and lower thoracic spine, and decreased range of motion of the cervical spine in all planes. Non-specific tenderness of the cervical and upper back area was also noted. A CT scan of the head was then performed on 06/13/07, which was entirely normal. The patient began treatment with Dr. on 06/13/07. Six weeks later, on 07/16/07, Dr. referred the patient for a psychological evaluation to assist “with development of a realistic treatment plan to expedite this patient’s recovery, including determination of her behavior health care needs.” The evaluation, performed by Ms., documented that the patient had undergone primarily passive modality therapy at Dr. office and that she was “feeling better with her overall level of pain.” Her pain level, however, was said to be 5-6/10 and was described as “marked pain.” At the time, the patient was taking only Cyclobenzaprine, a muscle relaxant, and Naproxen. Six sessions of individual psychotherapy were

recommended by. On 07/17/07, a cervical MRI was performed and demonstrated non-specific disc bulges at C5-C6 and C6-C7 with no evidence of nerve root compromise, spinal stenosis, or focal disc herniation. Electrodiagnostic studies of the upper extremities were then performed on 07/19/07 by Dr. and demonstrated no evidence whatsoever of radiculopathy, but evidence of right median nerve neuropathy consistent possibly with carpal tunnel syndrome. On 07/25/07, Dr. referred the patient to Dr. for a pain management evaluation. Dr. noted the patient’s pain level of 5/10. Physical examination was entirely normal, involving the head, neck, and spine. There was no tenderness to palpation of the posterior cervical musculature, no cervical muscle spasms, and normal cervical range of motion. There was no abnormality in the upper extremities or the thoracic spine. There was no tenderness of any muscles in the intrascapular area, no SI tenderness, and no tenderness of the lumbar spine of either muscles or bones. Neurologic examination was entirely normal with normal sensation, strength, and reflexes in the upper and lower extremities, as well as normal grip strength. Dr. noted that the patient had “no neurologic findings” and stated that she merely had a sprain/strain of the cervical and lumbar regions. He recommended returning her to light duty for one month. On

08/13/07, the patient was seen by Dr.. He noted the patient's continued neck and upper back pain, as well as intermittent numbness of the right arm. His physical examination, unlike that of Dr., documented non-specific tenderness throughout the lower cervical and upper thoracic muscles, decreased range of motion of the cervical spine in all planes, slightly decreased grip strength of the right upper extremity but negative Tinel's and Phalen's signs. Dr. recommended three epidural steroid injections (ESIs). A Designated Doctor Evaluation was performed on 10/16/07 by Dr.. He noted the patient's complaint of trapezius, lumbosacral, and cervical paraspinal muscle pain and aching. The physical examination, however, documented full range of motion of the neck, full range of motion of the lumbar spine, and non-specific tenderness to palpation of all of the muscles extending from the base of the spine to the base of the skull. The neurologic examination was entirely normal. Dr. awarded the patient a 0% whole person impairment rating stating she was at MMI as of 10/16/07. On 12/04/07, the patient was seen in follow-up by Dr., who noted continued complaints of right hand numbness and neck pain. Physical examination now documented normal range of motion, no muscle spasm, no trigger points, but crepitus in the anterior shoulder. Dr. continued the patient on Zoloft 25 mg. once per day and recommended a pain management program to address her depression. Dr. followed up with the patient on 01/15/08 and now stated that the patient had headaches, which he attributed to Zoloft, but which were not resolved with her discontinuation of Zoloft three weeks before. Dr. changed the patient from Zoloft to Paxil. On 04/09/08, the patient was evaluated by Mr.. The pain level remained at a level of 4/10. She had not fully met all of the goals of the chronic pain management program that she had been attending. On 04/14/08, a request for 10 additional sessions of a chronic pain management program was submitted by Mr.. In that request, Mr. noted the patient had completed nine sessions of individual psychotherapy as well as 19 sessions of a chronic pain management program. He noted there was no change in her pain complaint and that her frustration level had increased. Minimal reductions were noted in self-reported tension, anxiety, depression, sleep disturbance, and forgetfulness. Minimal improvement in ranges of motion in the right wrist and cervical spine were also documented over the four months of the chronic pain management program from 12/04/07 through 04/09/08. Dr. recommended non-authorization of the request for an additional 10 sessions of the chronic pain management program on 04/15/08, citing ODG treatment guidelines. On 04/29/08, Ms. wrote a letter requesting reconsideration for the request of 10 additional sessions for the chronic pain management program. In that request, she merely restated all of the information provided by Mr. in the original request. Dr. reviewed the recommendation on 05/02/08 and also recommended non-authorization of the request, citing ODG Guidelines.

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

ODG treatment guidelines do not recommend more than 20 sessions of a chronic pain management program unless there is a “clear rationale for the specified extension and reasonable goals to be achieved.” Additionally, medical literature, specifically an article by Sanders, et. al. in 1999, stated that no more than 20 sessions of a chronic pain management program would be medically reasonable or necessary unless there are specific reasons for extension of the program. In this case, there are clearly absolutely no extenuating or extraordinary circumstances regarding this patient’s alleged work injury nor her progress through treatment. In fact, the extent of the patient’s injury appears to be nothing more than a mild cervical strain. Multiple independent evaluations, including that of the Designated Doctor have clearly showed the complete lack of any physical examination evidence of significant abnormalities in either musculoskeletal or neurologic systems. Furthermore, all of the objective tests performed on this patient have failed to demonstrate any evidence of structural pathology or electrodiagnostic evidence of radiculopathy which would support her ongoing pain complaints. This patient has had not only 20 sessions of a chronic pain management program but, in addition, nine sessions of individual psychotherapy. She has, therefore, had more than a sufficient amount of treatment for her alleged chronic pain syndrome. There is nothing extraordinary regarding this patient’s alleged injury or clinical condition that would necessitate extending the chronic pain management program beyond the usual 20 sessions. Nothing in the medical documentation provided by the requester is indicative of any extenuating or unusual circumstances which would justify ignoring both ODG treatment guidelines and medical literature regarding the lack of necessity for more than twenty sessions of a chronic pain management program to achieve clinical results. Therefore, the recommendations of the two independent physician advisors regarding non-authorization of the request for an additional 10sessions of a chronic pain management program are upheld. There is no medical reason or necessity for 10 additional sessions of a chronic pain management program.

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 AND KNOWLEDGE BASE**
- 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)**

Sanders, et. al.