Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 29, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed chronic pain management program 30 sessions

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

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is Board Certified in Psychiatry, and is engaged in the full time practice of psychiatric medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

XX Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.10	97799		Prosp	30					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-17 pages

Respondent records- a total of 63 pages of records received to include but not limited to: Request for an IRO forms; letters, 4.3.08, 5.7.08; Recovery notes, 1.15.08-5.1.08

Requestor records- a total of 59 pages of records received to include but not limited to:
Recovery notes, 8.8.07-5.12.08

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old woman who had a slip and fall injury on xx/xx/xx. She has been treated with multiple surgeries, medications, physical therapy, and other conservative care; at the time of the proposed procedure she was on a fentanyl patch and Norco. She has had a recent sacroiliac joint injection with significant benefits. She has a history of anxiety and bipolar disorder. She had also previously been treated in a chronic pain management program. The initial evaluation from the chronic pain management program indicated a diagnosis of an adjustment disorder with mixed anxious and depressed moods, a pain disorder, and a proposal to be admitted for a 6-week chronic pain management program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE FOR DECISION: According to the ODG outpatient pain rehabilitation program, it may be considered medical necessity when all of the following criteria are met:

1. An adequate and thorough evaluation has been made including baseline function and old testing to follow-up with the same test and can note functional improvement.
2. 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 other treatments would clearly be warranted.
5. The patient exhibits motivation to change and willing to forego secondary gains including disability payment to affect this change.
6. Negative predictors of success have been addressed.

Additionally, the ODG comments that the total treatment duration for such a program should 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. The submitted material from the time of the request for the chronic pain management program does not support the medical necessity of the program.

There are a number of factors that lead me to this conclusion. First, the assessment that was submitted was inadequate in providing functional measures for monitoring improvement and the physical therapy component. There was no initial functional capacity in the examination or objective measures conducted to allow monitoring of improvement in the physical therapy component of the chronic pain management program. Secondly, it appears that the treating provider thought that radiofrequency ablation would be indicated given her significant response to the sacroiliac injections. While there is an initial denial for this, it is not clear whether the appeal for this was accomplished and there appears to be subsequent notes for further requests for this. Thirdly, the patient at this time apparently is working part time and it is not specified exactly how the chronic pain management program is going to interact with her work schedule or taking her off work would generally not be recommended as it has a potential to lead to regression.

Furthermore, there appears to be a discrepancy between the treating provider's notes and the pain program's notes with respect to whether she has pain behaviors and the degree to which she is experiencing anxiety and depression. The treatment note most proximal to the initial evaluation by the chronic pain management program, which is only 2 days before, does not note pain behaviors and documents a normal mental status examination and a negative review of systems for psychiatric issues. Finally, the requested program is 30 sessions long, which is in excess of what is recommended by ODG, while with the appeal documentation, the requesting provider indicates that he would be willing to start with 10 sessions. There is no modification of the program submitted to follow ODG recommendations of 20 sessions.

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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- XX 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)