

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 20, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of Chronic pain management program times ten sessions (eighty hours as related to the low back).

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity does not exist for Chronic pain management program times ten sessions (eighty hours as related to the low back).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office notes, Dr. 3/25/08, 05/05/08, 06/10/08, 07/28/08, 08/11/08, 08/14/08, 08/25/08, 08/28/08, 09/02/08, 09/18/08, 09/23/08, 10/07/08

Botox injection, Dr. 8/4/08

SI joint injections (right and left), Dr. 8/5/08, 08/06/08

Adverse Determination Letters, 8/8/08, 09/24/08

ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male with an injury date of xx/xx/xx when he was pinned between a truck and oil tank. The records do not provide a history regarding his clinical course prior to 2008. As of 03/25/08 the claimant was treating with pain management physician Dr. for chronic neck and low back pain. He was using a cane. Medications included Xanax, Nexium, Ambien, Soma, Norco and Neurontin. At the 07/28/08 visit the claimant indicated that the Norco was not working and the pain level had increased. The claimant had cervical and lumbar tenderness, decreased motion and spasm. Straight leg raise was positive bilaterally. The claimant had tenderness at the sacroiliac joints and positive Patrick's test. There was decreased sensation in the right L5-S1 distribution. The physician recommended Botox for the lumbar paravertebrals and discussed sacroiliac joint injection. The claimant was placed on Avinza with Norco for breakthrough pain. There was mention of a prior cervical fusion and lumbar microdiscectomy but the dates were not provided. The claimant underwent Botox injection on 08/04/08, right sacroiliac joint injection on 08/05/08 and left sacroiliac joint injection on 08/06/08.

Good results were noted with the sacroiliac joint injections. The Botox did not provide significant benefit. Stretching exercises were demonstrated at the 08/14/08 visit but Dr. noted on 08/25/08 that the claimant was not tolerating exercises and had increased pain with exercise. He was also complaining of depression due to the low back pain. The physician discussed a chronic pain management program 10 sessions. Cymbalta was ordered and the Avinza was increased to 60 mg twice a day. The pain management program was denied on peer review. Dr. indicated in the note of 09/18/08 that ODG guidelines 2008 did not require mental health evaluation and that there was no mental health provider within 90 miles who would accept work comp. She noted that the goal was to improve all functional levels. The claimant had very poor ADL capability, significantly decreased range of motion of the lumbar spine and muscle strength in the bilateral lower extremities. Ambulation was poor with a cane. Depression counseling would be provided to decrease depression symptoms.

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

Request is for medical necessity of chronic pain management program, 10 sessions, 80 hours, as related to low back.

Review of the records provided, supports the claimant is a gentleman with chronic low back pain, neck pain, status post C5-6 and C6-7 anterior cervical discectomy and fusion, status post lumbar microdiscectomy. The injury date was xx/xx/xx. Currently not working. Reported chronic low back pain. He had been on hydrocodone for years. Also treated with Xanax, Lyrica, Norco, Soma, and Lidoderm patch.

Based solely on review of the records provided and evidence-based medicine and ODG guidelines, the reviewer cannot approve chronic pain program, 10 sessions or 80 hours as medically necessary. It is unclear if the claimant has recently had physical therapy, stretch, strength or range of motion modalities, as the claimant is not tolerating a home exercise program. It is unclear if the claimant exhibits motivation to change and is willing to forgo secondary gains. It is unclear if the negative predictors have been addressed by a psychological evaluation or psychological care.

Based on the above issues, consistent with evidence-based medicine and ODG guidelines, the reviewer cannot recommend the proposed multidisciplinary chronic pain management program to be medically necessary at this time. The reviewer finds that medical necessity does not exist for chronic pain management program times ten sessions (eighty hours as related to the low back).

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Pain: Chronic Pain Programs.

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 KNOWLEDGBASE
- 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)