

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 8/20/2009
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97799 (CP) Chronic Pain Program 10 sessions

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from and completed training in Physical Med & Rehab at. This reviewer is also boarded in Pain Management. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 7/1/2006 and currently resides in.

REVIEW OUTCOME:

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

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

97799 (CP) Chronic Pain Program 10 sessions Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW
INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female whose date of injury is listed as xx/xx/xx. The requested chronic pain management program for 10 sessions has been submitted for IRO review. The case was first reviewed by , Ph.D. and secondly by , M.D. The notes indicate that the patient sustained a closed fracture of the left foot, derangement of the left knee, injury to the right shoulder, and upper arm. The patient was walking and slipped off the sidewalk hurting her right foot. The patient also fell to her knees, and immediately after the accident noticed extreme pain in the ankle and knee. The notes indicate that the ankle was markedly swollen, and underwent radiographs. There was

no evidence of fractures. The injury was felt to include only soft tissue and a compression-type bandage was applied which did not provide substantial relief. The patient underwent substantial physical therapy according to the notes. The notes indicate the patient underwent MRI of the left foot which noted subcutaneous edema across the dorsum and distal forefoot with degeneration of the flexor plates and mild cartilage loss consistent with osteoarthritis, as well as osteoarthritis at the MTP joints. There was no evidence of fracture. The patient complains of pain 2/10 per the note dated 08/06/09 with medications. The most recent physical examination revealed the patient had temperature differences, left greater than right, without allodynia over any portion of the left lower extremity. Peripheral pulses were normal and capillary refill was excellent. Sweat pattern examination shows definitive decreased sweating in the left foot compared to the right and motor strength was globally decreased in the flexors and extensors, as well as invertors and evertors of the left ankle. Range of motion in the knees and hips were normal. The patient is diagnosed with reflex sympathetic dystrophy of the lower extremity. The patient was recommended for diagnostic/therapeutic sympathetic nerve block on the left. Bone scan was carried out on 07/02/09 which noted increased tracer activity involving the right calcaneus and distal right first metatarsal. The request for pain management noted the patient was diagnosed with axis I pain disorder with both psychological and general medical condition chronic, as well as axis IV diagnosis of chronic pain associated with neck, arm, loss of job, financial struggles, multiple social losses, and problems with family. The patient's BDI was 33. BAI was reported as 14. The note indicates the patient is not a candidate for surgery and guidelines have been met.

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

The patient has been established as a candidate for a lumbar sympathetic block, both therapeutic and diagnostic, for chronic regional pain syndrome. The patient has not been shown to have failed all primary and secondary medical treatments prior to a tertiary pain program. The patient does have evidence of depression and pain disorder; however, has not completed treatment. Furthermore, there is no evidence the patient has been treated with lower levels of care to include individual psychotherapy or oral medications for depression. Based on the information submitted, the denial for the request is upheld.

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
- X** 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)

ODG- Multidisciplinary Pain Management Program Criteria (p. 40)