

## Notice of Independent Review Decision

**DATE OF REVIEW:** 2/23/2009

**IRO CASE #:**

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

CPT: 97799 (Chronic Pain Management Program x 30 days)

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. 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 Pain Management since 9/9/2006. This reviewer currently resides in TX.

**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)

CPT: 97799 (Chronic Pain Management Program x 30 days) Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Notice of assignment by dated 02/04/2009
2. Clinical note by dated 02/04/2009
3. Pre authorization dated 12/09/2008 and 12/17/2008
4. Fax page dated 02/03/2009
5. IRO request form dated 02/03/2009
6. Request form dated 02/03/2009
7. Request for independent review by dated 02/03/2009
8. Pre authorization dated 12/09/2008 and 12/17/2008
9. Review of case assignment by dated 02/04/2009
10. Clinical note dated unknown.
11. Fax page dated 02/04/2009
12. Notice of utilization review by dated 02/04/2009
13. IRO request form dated 02/03/2009
14. Request form dated 02/03/2009
15. Request for independent review by dated 02/03/2009
16. Pre authorization dated 12/09/2008 and 12/17/2008
17. Fax page dated 12/03/2008
18. Request for preauthorization of treatment by PhD dated 12/03/2008
19. Behavioral medicine evaluation by PhD dated 11/21/2008
20. Functional capacity assessment dated 10/28/2008
21. Clinical note dated 10/20/2008
22. Office visit note by MD dated 10/08/2008
23. Office visit note by MD dated 10/10/2008
24. Fax page dated 12/08/2008
25. Request for peer to peer consultation by PhD dated 12/08/2008
26. Clinical note dated 12/08/2008
27. Official Disability Guidelines (ODG)

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The injured employee is a xx year old female who experienced a fall on xx/xx/xx. She underwent multiple surgical procedures including thoracic fusion T6-8, lumbar spine surgery, removal of thoracic spine hardware, and cervical spine fusion C5-7. Current medications are listed as Prevacid, Neurontin, and Darvocet.

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

The documentation submitted was completely reviewed. The injured worker is a xx year old female who experienced a fall on xx/xx/xx. She underwent multiple surgical procedures including thoracic fusion T6-8, lumbar spine surgery, removal of thoracic spine hardware, and cervical spine fusion C5-7. Current medications are listed as Prevacid, Neurontin, and Darvocet. The request is for Chronic Pain Management Program (CPMP) which has been denied on 2 prior reviews. Request for IRO is submitted.

The ODG recommends a 10 day trial followed up with interval functional and psychological testing to determine effectiveness of the program and medical necessity of additional treatment. Additionally, the ODG recommends only 20 sessions of a CPMP and rarely longer (only in noted exceptional circumstances). The request for a 30 day program is far beyond the recommendations of ODG without interval re-evaluation and beyond the standard recommendation of 20 days. The guidelines also note that a negative predictor for success is the duration of pre-referral disability time, which in this case is significant and was noted in the other denial letters. Therefore, the prior denial of 30 days of a CPMP is upheld as the request is not medically necessary.

**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)

AMR Tracking Num: 109099