



Notice of Independent Review Decision

DATE OF REVIEW: 1/21/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for (10) sessions of a chronic pain management program.

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

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 previously denied request for (10) sessions of a chronic pain management program.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Fax Cover Sheet/Comments dated 1/16/09, 1/15/09, 10/28/08.
- IRO Request Form dated 1/15/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 1/15/09.

- Request Form dated 12/31/08.
- Provider Information (unspecified date).
- Request for Appeal dated 11/25/08.
- Notice to Utilization Review Agent of Assignment dated 1/16/09.
- Instructions TO IRO Template (unspecified date).
- Notice of CompPartners, Inc. Of Case Assignment dated 1/16/09.
- Appeal Deny Letter dated 12/5/08, 11/6/08.
- Functional Capacity Evaluation dated 10/3/08.
- Evaluation Report dated 10/1/08.
- Pre-Certification Request dated 10/28/08.

No guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Working with a sledgehammer.

Diagnosis: Low back pain.

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

The claimant is a male who was injured on his job on xx/xx/xx, while working with a sledgehammer and he "felt his back lock up." He has had conservative treatment since that time and had been unable to return to work. There was no documentation to review from his primary treating physician. The claimant was referred to Healthcare Systems for evaluation "to determine appropriateness for a chronic pain management program (CPMP)." In that evaluation on 10/01/08, it was documented that the claimant had attended physical therapy, chiropractic adjustments, massage therapy, heat/ice and medications, but he continued to have chronic pain and functional impairment. His scores on psychological symptom measures were low and he was not diagnosed with a mental disorder. CPMP was recommended due to the claimant's functional deficits, fear/avoidance, and poor relaxation skills. A Functional Capacity Evaluation (FCE) on 10/3/08, documented that he could function at a medium level job, whereas his job requirements were determined to be Very Heavy. The request for CPMP was denied by a medical reviewer on 11/6/08. The denial was appealed on 11/25/08. The psychologist who saw the claimant for the evaluation on 10/1/08, provided some additional rationale for treatment, but no other documentation was submitted. That request was denied on 12/5/08. The request was then submitted to the Texas Department of Insurance for assignment of an Independent Review Organization. There was no additional documentation submitted for this review other than the previously submitted Evaluation and FCE from early October of last year, and Dr. 's appeal letter dated 11/25/08. There

was not adequate documentation to meet the guidelines for participation in a CPMP. The documentation of the claimant's psychosocial issues was rather weak, and there was no documentation of the claimant's medical treatment. Furthermore, the claimant was determined to be at maximum medical improvement (MMI) on 10/31/08. The denial is upheld. Criteria for the general use of multidisciplinary pain management programs are outlined in the ODG. *"Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous 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 surgery or other treatments would clearly be warranted; (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that these gains are being made on a concurrent basis. Total treatment duration should generally not exceed 20 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function."* The patient should be at MMI at the conclusion.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines, Treatment Index, 6th Edition (web), 2008, Pain-Chronic pain programs.

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).