



Notice of Independent Review Decision

DATE OF REVIEW: 3/9/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for chronic pain management, 80 hours (97799 CP CA).

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

Texas licensed Anesthesiologist

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 chronic pain management, 80 hours (97799 CP CA).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Request for Medical Dispute Resolution Letter dated 3/5/09.

- Appeal of Interdisciplinary Pain Management Program Treatment Letter dated 3/5/09.
- Notice to CompPartners, Inc. of Case Assignment dated 3/2/09.
- Cover Letter/Fax Cover Sheet/Request for Medical Reports dated 3/2/09, 6/24/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 2/27/09.
- Company Request for IRO/Request for a Review by an Independent Review Organization dated 2/19/09.
- Follow Up Office Visit Notes dated 2/12/09, 11/18/08, 10/21/08, 8/26/08, 8/15/08, 8/8/08, 7/30/08, 7/22/08, 7/15/08, 7/8/08.
- Preauthorization Review Summary Report dated 2/12/09, 2/5/09, 10/31/08, 9/15/08, 8/6/08.
- Request for Reconsideration Letter dated 2/11/09.
- Progress Letter dated 2/5/09, 7/1/08.
- Request for Preauthorization Letter dated 2/4/09.
- Notification Letter - Re-Scheduled Appointment dated 1/16/09.
- Impairment Evaluation 4th Edition Report dated 1/15/09.
- Report of Medical Evaluation Form dated 1/15/09, 10/10/08.
- Consultation Report dated 1/7/09.
- Behavioral Health Screening Assessment Report dated 1/7/09, 12/7/08.
- Physical Rehabilitation Evaluation Report dated 1/7/09.
- Physical Therapy Initial Evaluation Report dated 10/28/08.
- Texas Workers' Compensation Work Status Report Form dated 10/10/08, 7/30/08, 7/1/08.
- Report of Medical Evaluation Report/Letter dated 10/10/08.
- Review of Medical History & Physical Exam Report dated 10/10/08.
- Cover Letter/Request for Designated Doctor Form dated 9/25/08.
- Request for Physical Therapy Evaluation Letter dated 8/29/08.
- Functional Capacity Evaluation/Cover Letter dated 8/5/08.
- Lumbar Spine MRI Findings Report dated 7/16/08.
- Assignment of Proceeds, Contractual, Lien, and Authorization dated 7/16/08.
- Therapy Progress Notes dated 7/1/08.
- Progress Note dated 6/23/08.
- Examination Report dated 6/16/08.
- Treatment Plan Report (unspecified date).

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Female

Date of Injury:

Mechanism of Injury: Fell.

Diagnosis: Chronic low back pain.

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

This female had a history of low back pain since xx/xx/xx, when she fell. The claimant was diagnosed with chronic low back pain. According to the 01/07/09 medical note, there was low back pain. The pain was rated 3-9 on a 0-10 scale. The claimant was also depressed, has poor sleep, appetite and fatigue. On physical examination, there was tenderness and decreased range of motion. Sensory was normal. Straight leg test was negative bilaterally. The claimant was on Soma, Naproxen and Vicodin. The claimant has had multimodality conservative treatment including medications, physical therapy, biofeedback and counseling. An MRI from 07/16/08 was normal. The claimant had an evaluation by Dr. , with the conclusion that the claimant was a good candidate for a pain program. The request is now for chronic pain management - 97799 CP CA times 80 Hours. The Official Disability Guidelines state, "*Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: (a) Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances; (b) Excessive dependence on health-care providers, spouse, or family; (c) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (d) Withdrawal from social know how, including work, recreation, or other social contacts; (e) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f) Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or nonorganic illness behaviors; (g) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (2) The patient has a significant loss of ability to function independently resulting from the chronic pain; (3) 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; (4) The patient is not a candidate for further diagnostics, injections or other invasive procedure candidate, surgery or other treatments including therapy that would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note functional and psychological improvement; (6) The patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect this change; (9) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented.*" The claimant meets the above criteria and should be approved for the 10 sessions at 8 hours each, for a total of 80 hours over 2 weeks.

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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines (ODG), Treatment Index, 6th Edition (web), 2008, Pain -Criteria for the general use of multidisciplinary pain management 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).