

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 5/27/2009
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1. 20 sessions of chronic pain management program

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from and completed training in Physical Med & Rehab at 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.

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) |

1. 20 sessions of chronic pain management program Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a female who presents with pain disorder and major depressive disorder after a cervical spine injury on xx-xx-xx. Her symptoms include sad mood, pessimism, disturbed sleep, decreased appetite, fear, and nervousness. Her treatments have included individual psychotherapy and anti-depressant medication.

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

The female sustained an injury to her neck on xx-xx-xx when a TV fell and hit her head. After the injury her main complaints included depressed mood, pessimism, disturbed sleep, decreased appetite, fear, and anxiety. On the patient's 3/17/09 psychological evaluation it notes the patient has been treated with diagnostic testing, sutures,

injections, PT, individual psychotherapy, and medication. CT brain and EEG were normal. MRI of the brain revealed possible small increased vascularity in the left basal ganglia posteriorly. MRI of the cervical spine showed DDD and a mild C5-6 disc protrusion. EMG/NCV showed left C5 radiculopathy and bilateral CTS in both wrists. The patient eventually underwent ACDF at C3-4-5 at some point as noted by attempted CT myelogram report on 11/7/08. The evaluation notes the patient's level of pain at that time was 6/10, BDI score of 14/63, ODI of 60/100, and BAI of 25/63. Diagnoses are major depression and pain disorder. The patient was also noted to have had surgery on 11/5/08. The first denial notes of the request only contained psychological information and no information regarding medical clearance and did not reflect the fact the patient had cervical fusion surgery. The second denial stated that the treatment plan was "boiler plate" and did not specifically address the patient's dysfunction. In addition to these rationales (with which I concur), the Official Disability Guidelines (ODG) do not recommend initial approval of a 20 session chronic pain management program. ODG recommends that patients who meet the criteria for a pain management program first do a 10 session trial to assess for compliance and effectiveness of the program before submitting for a full 4 week course of treatment. Based on the ODG recommendations, 20 sessions of a chronic pain management program would not be considered medically necessary at this time. Therefore, the previous denial 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)