

Core 400 LLC

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DATE OF REVIEW:

May/07/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional Chronic Pain Management x 10 Sessions (5x/week x 2 weeks)

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 3/31/09, 3/9/09
ODG Guidelines and Treatment Guidelines
Request for Extension of CPMP, 2/10/09
Appeal of Denial for CPMP, 1/20/09
Patient Progress Records, Feb 2009, March 2009
CPMP, 3/2/09, 3/3/09, 3/4/09, 3/5/09, 3/6/09, 3/9/09, 2/23/09, 2/24/09,
2/26/09, 2/27/09, 2/20/09, 2/18/09, 2/17/09, 2/9/09, 2/10/09, 2/11/09,
2/12/09, 2/13/09, 2/2/09, 2/3/09, 2/4/09, 2/5/09, 2/6/09
FCE, 3/3/09, 2/10/09, 2/2/09
SOPA, 2/3/09
3/24/09, 3/4/09
MD, PhD, 3/27/09, 2/20/09, 2/12/09, 2/5/09, 3/13/09, 3/9/09,
12/18/08, 3/5/09, 11/26/08, 10/17/08
Neuro EMG, 11/11/08
2/12/09
BSI 18, 10/17/08
DDE, 10/10/08
Assessment, 12/31/08
MRI Cervical Spine, 12/10/08, 6/27/07
2/5/08

PATIENT CLINICAL HISTORY SUMMARY

This is a woman involved in a motor vehicle accident on xx-xx-xx. She developed neck and upper extremity pain. The MRI in August 2008 showed disc herniations at C5/6 and C6/7 with compression of the spinal cord, plus ossification of the posterior longitudinal ligament. She underwent (12/31/07) a decompression of the cord including a discectomy and partial vertebrectomy and anterior fusion at these levels. She continued to have neck pain and bilateral upper extremity pain. An EMG (11/11/08) confirmed the presence of the bilateral radiculopathy 10 months post surgery. A repeat MRI on 12/10/08 showed postoperative changes, but no cord compression. Dr. felt he had nothing else to offer her other than the pain management program. Mr. assessed her (12/31/08) and wrote "upon reviewing her medical records, I can find no physician's statement advocating an additional surgical or diagnostic procedure..." The Designated Doctor examination in October 2008 felt she was not at MMI, and may need a spinal cord stimulator. Dr. began seeing her on 10/17/08. The provider recommended a CPMP. The patient was in a program for approximately 20 sessions. Dr. described her as getting better and enthusiastic about her program. She had FCEs in February and March showing progress. She has been attempting to discuss a job with her employer. She apparently still has some cervical burning pain and left upper extremity pain. Dr. has requested an additional 10 sessions of the pain program in addition to the 20 she previously received.

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

The ODG requires specific goals and treatment program in order to extend CPMP by more than 20 days. The guidelines state "Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed)."

Dr. has written in the request that the additional 10 sessions are necessary for the patient to return to work with her prior employer. Dr. has also itemized the reasons for a pain program (2/10/09). From the first note by Dr. on 10/17/08 through the 3/27/09 note, treatment goals included pain relief, improved physical and social function, and the reduction of pain medications. The provider said that if these goals were not met, she would reevaluate the program, especially the medications. There is nothing in the records to indicate the goals for the extension of the program have changed. This particular request does not meet the requirement for an individualized treatment program. There is "no clear rationale for the specified program" nor was there a "individualized care plan(s) explaining why improvements cannot be achieved without an extension" nor are there the specific outcomes individualized for this person. This patient has shown improvement, however the records do not indicate that there is a valid reason to deviate from the 20-session limit established in the guidelines. The reviewer finds that medical necessity does not exist for Additional Chronic Pain Management x 10 Sessions (5x/week x 2 weeks)

12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (2005) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).

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

[] ACOEM-AMERICA 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)**