



Notice of Independent Review Decision

**DATE OF REVIEW:** 11/11/09

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for Chronic Pain Management Program / 80 hours (8 hours/day x 10 days) (97799-CP).

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

Texas licensed Physical Medicine and Rehabilitation/Pain Medicine physician

**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 Program / 80 hours (8 hours/day x 10 days) (97799-CP).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Notice of Utilization Review Findings dated 11/2/09.

- Fax Cover Sheet/Pre-Authorization dated 10/29/09, 9/10/09, 8/17/09.
- Review by an IRO Request dated 10/26/09.
- Addendum/Necessary Treatment Letter dated 9/28/09.
- Independent Medical Evaluation/Letter dated 9/21/09.
- Determination Letter dated 9/18/09.
- Authorization Request Letter dated 8/21/09.
- Pre-Authorization Request dated 8/10/09.
- Multidisciplinary Chronic Pain Management Physical Therapy Goals dated 8/10/09.
- Appeal Letter dated 8/8/09.
- Patient Information/FCE Report dated 8/6/09.
- Behavioral Medicine Evaluation dated 7/30/09.
- Daily Progress Note dated 7/7/09, 7/1/09, 6/29/09, 6/26/09, 6/24/09, 6/23/09, 6/20/09, 6/19/09, 6/17/09, 6/15/09, 6/12/09, 6/10/09, 6/9/09, 6/8/09, 6/5/09, 6/4/09, 6/2/09, 5/29/09, 5/28/09, 5/22/09, 5/20/09, 5/11/09, 5/1/09, 4/27/09, 4/24/09, 4/23/09, 4/22/09, 4/21/09, 4/17/09, 4/16/09, 4/15/09, 4/13/09, 4/8/09, 4/6/09, 4/3/09, 4/1/09, 3/30/09, 3/19/09.
- Physical Assessment Evaluation and Treatment Plan dated 7/7/09, 5/28/09, 5/5/09, 1/28/09, 1/7/09, 10/20/08, 9/19/08, 8/11/08, 7/28/08, 7/10/08, 5/28/08, 4/3/08, 3/5/08, 1/24/08, (unspecified date).
- Pain Management Daily Progress Notes dated 9/19/08, 9/16/08, 9/10/09, 9/2/08, 8/19/08, 8/14/08.
- Individual Counseling Progress Note dated 9/19/08, 9/16/08, 9/10/08, 9/2/08, 8/19/08, 8/14/08.
- Weekly Schedule (unspecified date).

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

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:**

**Gender: M**

**Date of Injury: xx/xx/xx**

**Mechanism of Injury: Fell down wet steps at work.**

**Diagnosis: Musculoskeletal injury to cervical spine, left shoulder and low back.**

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

This male sustained an occupational injury to the cervical spine, lumbar spine, and left shoulder on xx/xx/xx. On that date, he fell down wet steps at work resulting in multiple musculoskeletal injuries of the cervical spine, left shoulder, and lower back. He underwent left shoulder arthroscopic surgery in March of 2008 and developed postoperative frozen shoulder, which required an open shoulder surgery and manipulation under anesthesia in May of 2009. He

continued a home exercise program with regard to his left shoulder. His cervical spine pain level was 7 on a scale of 10 and low back pain was 8 on a scale of 10. He received ongoing rehabilitation management. Additionally, he underwent a functional capacity evaluation dated August 6, 2009, which was non-diagnostic because the claimant was unable to successfully provide adequate effort secondary to pain. He had also undergone a behavioral medicine evaluation, dated July 30, 2009. According to this evaluation, the claimant was found to be an appropriate candidate for the chronic pain management program. The claimant underwent the following diagnostic testing: Cervical spine MRI scan of January 7, 2008 demonstrating minimal disk space narrowing due to facet hypertrophy at C3-C4 and left neuroforaminal narrowing at C4-C5 secondary to degenerative changes. Additionally, on January 7, 2008, a left shoulder MRI scan demonstrated mild intrasubstance degeneration of the supraspinatus tendon, mild edema of the humeral head, and trace amount of fluid in the subacromial bursa. The lumbar spine MRI scan, of January 14, 2008, demonstrated central disk bulging at L4-L5 and L5-S1 levels. At L5-S1, there was an annular tear with minimal compromise of the neuroforaminal due to facet hypertrophy. The upper extremity electrodiagnostic studies, of March 7, 2008, demonstrated bilateral carpal tunnel syndrome and bilateral ulnar neuropathy at the wrist. The lower extremity electrodiagnostic study, of March 12, 2008, demonstrated evidence of focal left perineal nerve mononeuropathy. The prior non-authorization for this service was not accurate because the claimant did demonstrate compliance with a home exercise program and did receive appropriate antidepressant medication for associated depression management. The non-diagnostic functional capacity evaluation was based upon the claimant's inability to participate secondary to activity-related pain, which would be addressed by the chronic pain management program. The ODG support this decision stating, "Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity" and "Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains." Therefore, the previous denial is overturned.

**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, 7<sup>th</sup> Edition (web), 2009, Pain - Chronic Pain Management Program.
- 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).