



Notice of Independent Review Decision

DATE OF REVIEW: 12/02/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten Sessions of Chronic Pain Management Program

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

Board Certified in Physical Medicine & Rehabilitation

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.

Ten Sessions of Chronic Pain Management Program - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Examination Findings, M.D., 01/08/08, 02/05/08, 03/04/08, 03/18/08, 04/15/08, 05/13/08, 06/10/08, 07/08/08, 07/15/08, 08/19/08, 09/16/08, 10/14/08, 11/11/08,

- 12/09/08, 01/06/09, 02/03/09, 03/03/09, 03/31/09, 04/14/09, 04/21/09, 04/28/09, 05/19/09, 06/02/09, 06/16/09, 06/30/09, 07/07/09, 07/14/09, 07/21/09, 08/04/09, 09/01/09, 10/06/09
- Physical Performance Evaluation (PPE), Clinic, 12/07/07, 03/05/08, 11/12/08, 12/29/08, 03/25/09, 07/20/09
 - EMG, D.O., 02/14/08
 - MRI of Upper Extremity Joint, Imaging, 04/17/08
 - Designated Doctor Evaluation (DDE), M.D., 04/18/08
 - Physical Therapy, Health, 07/07/08, 07/09/08, 07/11/08, 07/14/08, 07/16/08, 07/18/08, 07/21/08, 07/23/08, 07/30/08, 07/31/08, 08/01/08, 08/04/08, 08/06/08, 12/04/08, 12/05/08, 12/08/08, 12/09/08, 12/11/08, 12/16/08, 12/17/08, 12/18/08, 12/19/08, 12/31/08, 01/02/09, 01/05/09, 01/20/09, 01/21/09, 01/22/09, 01/26/09, 01/27/09, 01/29/09, 02/02/09, 02/03/09, 02/04/09, 02/10/09, 02/11/09, 02/12/09
 - Functional Capacity Evaluation (FCE), Clinic, 09/10/08, 02/09/09
 - Evaluation, LPC, 03/02/09
 - Chronic Pain Management Program, 03/16/09, 03/24/09, 03/31/09, 04/13/09, 04/20/09, 04/27/09, 07/06/09, 07/13/09, 07/20/09, 07/27/09
 - Pre-Certification Request, Rehabilitation Center, 06/29/09, 08/31/09
 - Denial Letter, Services Corporation, 09/04/09, 10/09/09
 - Request for Appeal, Rehabilitation Center, 09/25/09
 - The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient sustained work-related injuries to his neck and left shoulder. He had undergone physical therapy, MRI's of the left shoulder and EMG studies. The patient also underwent a left shoulder arthroscopy with rotator cuff repair. His most recent medications he had been treated with were Hydrocodone, Zanaflex, Lyrica, Prilosec, and Ambien.

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

The date of injury is over two years in age. The patient is over one year removed from undergoing definitive treatment to the left shoulder in the form of surgical intervention. The records available for review document that past treatment has included access to 30 sessions of treatment in the form of a comprehensive pain management program. Per the criteria set forth by the Official Disability Guidelines, additional treatment in the form of a comprehensive pain management program would not be considered of medical necessity. The submitted medical documentation does not provide data to indicate that there has been a significant improvement in functional capabilities with 30 sessions of treatment in the form of a comprehensive pain management program. Additionally, there has not been a documented marked reduction in prescription medication utilization with treatment in the form of a comprehensive pain management program.

The Official Disability Guidelines typically support a maximum of twenty sessions of treatment in the form of a comprehensive pain management program. Additionally, to justify ongoing treatment in the form of a comprehensive pain management program, Official Disability Guidelines indicate that there must be sufficient documentation to indicate that there are improvements in functional abilities and documentation of decreased medication utilization. The records available for review do not provide documentation that there has been a significant improvement in functional capabilities and a significant decrease in prescription medication utilization to support a medical necessity for ongoing treatment in the form of a comprehensive pain management program.

Per criteria set forth by the Official Disability Guidelines, it is realistic to expect that maximal benefit from treatment in the form of a comprehensive pain management program has been accomplished. Hence, based upon the records available for review, medical necessity for ongoing treatment in the form of a comprehensive pain management program is not presently established based upon the records available for review.

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
- 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)**