

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 9/11/2009
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CPT 97799: Chronic Pain Management Program 10 sessions.

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Texas Medical School and completed training in Anesthesiology/Pain Management at University of Texas Medical School. 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 Anesthesiology since 1993.

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) |

CPT 97799: Chronic Pain Management Program 10 sessions. Upheld

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a xx year old male with a history of thoracic, low back, and left lower extremity pain complaints. These complaints follow a reported "slight pull" in his back. Previous treatment has included conservative care and work hardening. He has completed 20 (of approved 20) sessions in an interdisciplinary pain management program. The current request is for a 10 session continuation of the program.

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

The injured employee is a xx year old male with a history of thoracic, low back, and left lower extremity pain complaints. These complaints follow a reported "slight pull" in his back. Previous treatment has included conservative care and work hardening. He has completed 20 (of approved 20) sessions in an interdisciplinary pain management program. The current request is for a 10 session continuation of the program. The injured employee has completed, in addition to the 20 sessions of the CPMP, 10 days of a work hardening program. The injured employee is on no narcotics and only Naprosyn. There was no improvement noted after 20 days with respect to the injured employee pain score, anxiety, or sleep disturbances. There was demonstrated 90% reduction in the depression index. The

injured employee is on no documented antidepressants. The ODG criteria stance is as follows: 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). (Sanders, 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). Based on this and the lack of significant improvement other than the depression index, further sessions are not considered medically necessary. The recommendation is to uphold the previous denial.

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)