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DATE OF REVIEW: 04/06/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 sessions of Chronic Pain Management

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

This case was reviewed by a Texas licensed MD, specializing in Psychiatry. The physician advisor has the following additional qualifications, if applicable:

ABMS Psychiatry and Neurology: Pain Medicine, Psychiatry and Neurology: Psychiatry, Psychiatry & Neurology: Forensic Psychiatry
 Psychiatry

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
10 sessions of Chronic Pain Management	97799	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request	TDI	16	03/17/2010	03/17/2010
2	Appeal Denial Letter		7	03/01/2010	03/15/2010
3	IRO Record Receipt		4	03/17/2010	03/17/2010
4	FCE Report	Medical Centers	11	12/30/2009	12/30/2009
5	Initial Request		2	03/02/2010	03/02/2010
6	IRO Request		5	03/15/2010	03/17/2010
7	Psych Evaluation		15	12/17/2009	12/17/2009
8	Initial Denial Letter		3	02/24/2010	02/24/2010

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an IRO for a request of 10 sessions of chronic pain management for a male with a history of a right knee injury on xx/xx/xx and subsequent knee surgery times x 2 with chronic knee pain. The treating physician states that the injured worker underwent a multidisciplinary evaluation (2-17-09) (*this must be the wrong year on the report*) that diagnosed the injured worker with a Pain disorder with psychological factors and a general medical condition (depressive and anxious symptoms) with a GAF of 60 and recommended a chronic pain program. The treating physician reports the injured worker fulfills ODG guidelines for the

requested 10 sessions. The carrier has denied treatment based upon the fact that there were not documented physical therapy notes other than "vague" mention of 12 sessions of aquatic therapy and "no mention" of the home exercise program in conjunction with the pain medications prescribed. The initial denial was based upon the absence of identifiers for negative predictor for success in a chronic pain program as well as an absence of records to document all levels of treatment have been tried without success and how negative predictors of treatment will be addressed in a chronic pain program.

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

The previous denial of the chronic pain program is upheld. The records reviewed indicate the psychosocial evaluation was not carefully performed and reliable. For example the Fear Avoidance Belief Questionnaire has responses that relate to fear of injuring his back. His medication listed is Hydrocodone 800 mg. (an impossible dose). Additionally, his depressive and anxious symptoms have not been treated with typical medications for these problems that will likely reduce these symptoms as well as his pain complaints and finally, I agree with the previous reviewer who notes there is an absence of documentation about his aquatic therapy as well as his home exercise program. The reasons for not requesting lower levels of care, such as combined medication management with cog-behavior therapy and home exercise program are not adequately addressed in the request for services.

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

3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

- 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

- X 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)