Specialty Independent Review Organization

AMENDED REPORT 11/29/2010

Notice of Independent Review Decision

DATE OF REVIEW: 11/24/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a chronic pain management program 80 hrs at a rate of 8 hrs/day for 10 days. (97799)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer performs this type of service in daily practice and has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a chronic pain management program 80 hrs at a rate of 8 hrs/day for 10 days. (97799)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): 8/31/10 denial letter, undated note by MD, 8/25/10 CPM request, 8/19/10 repeat interview by, LPC, treatment plan, 6/7/10 PPE, 2/12/10 through

5/21/10 notes by MD, 3/30/10 operative note, 8/17/09 through 4/7/10 notes by DC, 1/4/10 operative note, 10/4/10 denial letter with report by Ph D and 9/27/10 recon letter and script.

11/9/10 letter by Ph D.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, this injured worker had a work related injury to his lower back on xx/xx. The patient was treated with multiple conservative modalities and had a functional capacity evaluation performed on July 30, 2009 which demonstrated that he was able to perform in a near-heavy PDL. He underwent a trial of return to work, but this increased the pain in his lower back. He was evaluated by D.C. on August 17, 2009. At that time, he had tenderness to palpation in the lumbar region and a negative straight leg raise. He was complaining of back pain radiating to his right groin and leg. Diagnoses of lumbar radiculitis, lumbar strain/sprain, and lumbar facet syndrome were made at that time. There was a recommendation that he be evaluated by M.D. for possible facet joint injections.

On January 4, 2010, the patient underwent right L4 and L5 diagnostic medial nerve branch blocks. He underwent three sessions of physical therapy following these injections. According to Dr. note, he received two weeks of pain relief following the diagnostic injections. On March 30, 2010, Dr. performed radiofrequency thermocoagulation at right L4, L5, and S1 levels. He received three sessions of active care therapy post procedure.

Dr. re-evaluated the patient on April 23, 2010 and noted that he had a chronic pain syndrome secondary to lumbar facet dysfunction. This had improved with radiofrequency thermocoagulation and at the time of that evaluation, the patient had a pain level of 2 to 3 on a base of 0 to 10. Dr. recommended a short course of anti-inflammatory drugs and muscle relaxers for four weeks. He stated that “if he continues to do well, no further treatment is planned.” On May 21, 2010, Dr. noted that he had had a temporary increase in back pain. On June, 7, 2010, a functional capacity evaluation was performed demonstrating that the patient met medium PDL requirements.

On August 19, 2010, he was evaluated by M.A., LPC. The interviewer noted that he had a psycho physiological condition that was preventing him from acquiring the level of stability needed to adjust to his injury, manage more effectively the pain, and improve his level of functioning. The interviewer reported that the patient’s Beck Depression Inventory was 16 which placed him in the mild to moderate range and his Beck Anxiety Inventory was 18 which placed him in the low to mild range for anxiety. A chronic pain management program was recommended.

On August 31, 2010, there is a denial of request for chronic pain management program from M.D. who stated that the injured worker had responded to radiofrequency neurotomy and that there was no indication that further procedures would not reasonably benefit the patient. ODG criteria, however, state that a neurotomy should not be repeated unless the duration of relief from the first procedure was documented for at least 12 weeks with greater than 50% relief of symptoms. There is no documentation that the injured worker's relief lasted for 12 weeks at greater than 50% level. In fact, there is documentation in August that the patient's pain level was 6, varying from 3 to 8 depending on his activities.

There was a Request for Reconsideration of the Denial for Chronic Pain Management Program and a second denial was issued from, Ph.D. on October 4, 2010 stating that the injured worker had had excellent relief of symptoms from radiofrequency thermocoagulation and that there was no indication that the pain level had increased to his pre-treatment level although the record indicates that his pain was averaging 6 and varying from 3 to 8.

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

At 18 months post injury, he still has a pain level that averages 6 and varies from 3 to 8 depending on the injured worker's activities. His current PDL level is medium and he has failed to reach his pre-injury status. He has accompanying psychological dysfunction as documented in the medical record including a sleep disorder, depression, anxiety, and disordered social functioning. His previous methods of treatment for his chronic pain have been insufficient and no other options are planned or are likely to provide significant clinical improvement. Negative predictors of success have been addressed in the medical record and there is documentation that the injured worker desires to return to work. He meets ODG criteria for a chronic pain management program.

Prior denials of the medical necessity of the requested services were based on rather nebulous factors including that there was no documentation that the patient would not benefit from repeat neurotomy. The ODG criteria, however, state that the neurotomy should not be repeated unless there is documentation that there was 50% relief from the first procedure lasting at least 12 weeks. Clearly, there is no such documentation in this medical record and a repeat neurotomy would not be indicated.

There is also a statement in the medical record from Dr. that the patient had excellent relief from his radiofrequency neurotomy and had previously increased his physical demand level. The fact remains, however, that his pain has recurred and is at a high level and his current PDL is medium, an insufficient

level to return to his prior work. Repeating previously unsuccessful conservative therapies offers no further hope for improvement. No other treatment options are recommended or planned.

Given the above factors, the reviewer feels there is a prospective medical necessity of a chronic pain management program, 80 hours at a rate of 8 hours a day for 10 days. This individual meets ODG criteria for the requested service.

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)**