

Wren Systems

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97799 Chronic Pain Management Program 5xwk x2wks; 10 Sessions

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

M.D., Board Certified, Orthopedic Surgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/15/09, 11/12/09

Injury Clinic 8/17/09, 10/13/09, 11/5/09, 4/2/09, 4/6/09, 7/25/08, 8/4/08, 8/6/08, 8/11/08, 8/13/08, 9/3/08, 9/29/08, 10/15/08, 4/1/09, 4/10/09, 4/14/09, 4/28/09, 4/30/09, 10/14/09, 11/11/09

Physical Performance Eval. 8/10/09

D.O. 9/17/09, 8/13/08, 9/11/08, 10/9/08, 11/6/08, 12/11/08, 1/8/09, 2/12/09, 3/19/09, 6/11/09, 9/17/09, 7/23/08

Hospital 11/21/05

Medical Imaging 2/16/07

Functional Abilities Evaluation 8/20/09

Neurosurgical & Spine 11/14/08

Report of Medical Evaluation 1/25/08, 1/28/08

M.D. 1/25/08

D.O. 1/28/09

9/11/09, 12/7/09

Claims Management 12/18/09

Claims Management 1/11/06

Supplemental Report of Injury 7/15/05

Health System 3/11/05

Rehab 3/17/05, 4/11/05

Physician Record 3/21/05, 3/23/05, 3/30/05, 4/11/05, 4/26/05, 5/11/05, 6/7/05, 7/15/05

M.D. 5/31/05

M.D. 11/16/05, 11/30/05, 12/14/05, 1/11/06

Medical Narrative 1/31/06

Health 4/26/06

Orthopaedics Specialists 5/1/06

ODG, Pain, Chronic Pain Programs

PATIENT CLINICAL HISTORY SUMMARY

This patient is a woman with a date of injury of xx/xx/xx. This patient alleges that she was struck

under the chin and propelled 10 – 12 feet through the air as a result. The CT scan of the face noted no fractures to the facial bones. PT notes dated July 25, 2008 indicate that the injured worker was being evaluated for shoulder, low back and left ankle problems. The physical examination noted tenderness to the cervical, left shoulder and thoracic and lumbar spine. In August 2008 Ed. completed a behavioral health review and diagnosed an adjustment disorder with a pain disorder. Additional psychological testing was requested. Physical performance testing was also completed. In August 2008, Dr. felt that a chronic pain program was indicated for this injured worker. The additional psychiatric testing showed that sleep issues had developed requiring intervention, as per Ph.D. Dr. referred the patient to orthopedics and neurosurgery for consultation as well as a chronic pain protocol, all at the same time. Several sessions of individual psychotherapy were completed. A Designated Doctor evaluation from Dr. noted that the injury was limited to the lumbar spine and rotator cuff. A second Designated Doctor evaluation, this one from Dr., noted maximum medical improvement and assigned a 12% whole person impairment rating. Dr. continued to treat the injured worker and made determinations that were not supported by the Designated Doctor (specifically; adhesive capsulitis when there is a near full range of motion). Surgical intervention had not been ruled out. Injection therapy had been rejected by the injured worker. A reconsideration for additional psychotherapy was noted. The evaluation also indicated that the unrelated co-morbidities of hypertension and diabetes were not under control.

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

Dr. has noted that significant lumbar canal disease and stenosis unrelated to this reported mechanism of injury is present and feels that this would be best addressed with a chronic pain protocol. The injured worker elected not to pursue lower levels of care. It was also noted that the patient does not qualify for a work hardening program. Multiple boilerplate documents are noted to support the request for this protocol.

The patient does not meet the multiple parameters outlined in the ODG for entrance into a chronic pain management program. When considering the age and body habitus of this patient, and that there is no apparent desire to control the symptoms or treat the lesions noted; it is clear to this reviewer based on the records that there is no medical necessity for this type of program. There is no clear clinical indication for this request and therefore the adverse determinations are upheld. The request does not conform to the ODG and no reason has been provided for why the guidelines should not be followed in this particular patient's case. The reviewer finds that medical necessity does not exist for 97799 Chronic Pain Management Program 5xwk x2wks; 10 Sessions.

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

- ACOEM-AMERICA 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)