

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/06/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

30 days of Chronic Pain Management Program

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

MD, Board Certified in Psychiatry and Neurology

**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**

OD Guidelines

Adverse Determinations, 6/3/10, 6/10/10

Ph.D. and Associates, 6/16/10, 12/3/09, 5/24/10, 5/13/10, 5/28/10

Second submission of documents, 7/1/10

IRO Summary, 6/30/10

Designated Doctor Examination, 6/3/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male who was employed as a at the time of his injury, on xx/xx/xx. He injured his low back and left hip when he fell off a chair, landing on concrete and hitting the left side of his body. An MRI revealed an abnormality at the L3-4 disc. He had surgery on his hip on 9/15/2009, followed by PT, followed by a work hardening program ending in January 2010. He experienced some improvement in his hip, but continues to have low back pain. An EMG has revealed nerve damage in his low back and records indicate he may need a spinal fusion of that area. His pain is constant at a level of 8/10. A mental health evaluation has given him a diagnosis of Adjustment Reaction, chronic, associated with a medical condition and pain. The treatment team requested a 30-day chronic pain management program. The request included the following criteria: pain persisting beyond the expected healing time, a heightened dependency on others, including health care providers, excessive use of health care services, prolonged physical functional capacity deficits, pain related general dysfunction and adverse impact on physical, vocational, and psychological functioning leading to significant decreases in quality of life, failure of primary

and secondary conservative treatment alternatives and perceptions of disability. The insurance company reviewer denied the request, stating that ODG guidelines allow two weeks chronic pain management after which a re-evaluation is required for compliance with significant demonstrable efficacy and demonstration of subjective and objective gains.

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

The insurance company reviewer denied this request, stating that ODG guidelines allow two weeks chronic pain management after which a re-evaluation is required for compliance with significant demonstrable efficacy and demonstration of subjective and objective gains. This patient meets all other ODG criteria for admission to a chronic pain management program. The reviewer sees in the notes that after the first denial, the provider sought to limit his request to 10 days of treatment and was denied the opportunity to change the request. One year after his injury, the treatment team in this case has clearly demonstrated that this patient would be appropriate for chronic pain management treatment. He meets all criteria. However, because the reviewer is not permitted to partially overturn this determination, and because the provider was not permitted to change his request, this reviewer must uphold the original determination. The reviewer finds that medical necessity does not exist for 30 days of Chronic Pain Management Program.

**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)