



MEDICAL RESOLUTIONS



REVIEWER'S REPORT

DATE OF REVIEW: 06-08-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management program 5x2

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

Clinical psychologist; Member American Academy of Pain Management

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant is a male who sustained a work-related injury on xx/xx/xx while performing his usual job duties as a maintenance worker at a correctional facility. Records indicate that on the above-mentioned date, claimant was injured when a metal bunk bed struck him in the head and shoulder area, resulting in injuries to his head, neck, and left UE. Patient continued to work for several weeks with continually worsening symptoms, and eventually sought at the ER on 8/20/09. Patient continues to report pain and functional difficulties and has not returned to work.

Records available for review indicate that over the course of his treatment, patient has received x-rays; MRI's of the brain, neck, and left shoulder;

physical therapy; medication management; rotator cuff repair surgery; Work hardening/work conditioning; and individual counseling.

On 4-6-10, patient was seen by Dr. who recommends cervical epidural blocks and re-exam in 2 months. On 4/21/10, patient was released to work full time without restrictions by a designated doctor who gave the patient a 10% whole person IR. FCE of 04-26-10 shows patient to be performing at the light PDL, below what is required for return to work. FCE also notes that patient is "pending surgery of the cervical spine."

Patient was evaluated by xxxxxon 4-27-10, where they found the following symptoms remaining after patient's individual therapy sessions: BDI of 36 (up from 31), BAI of 7 (down from 16). The current request is for initial 10 days of a chronic pain management program. Goals of the program are to: "improve functioning, decrease pain, decrease dependency on health care system, improve patient mobility, improve sleep duration, address self-defeating thoughts, address isolation and hostility, and minimize distress caused by injury-related anxiety and depression."

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

ODG states that "an adequate and thorough evaluation" has to have occurred, which should include baseline functional testing so follow-up with the same test can note improvement or lack thereof. In this follow-up report, there are no specific and objective end treatment goals in the behavioral report for this patient, no baselines, no history of the injury and intervening response to treatments, and no mental status exam. There is also no assessment of current pain levels or patterns, and no explanation why individual therapy was discontinued or how many sessions were even applied. Standardized testing using the BDI and BAI were done pre and post IT sessions, but, again, there is no explanation for why patient's depression index worsened during the course of treatment.

There is also no explanation regarding the surgeon's recommendation for injections, and whether or not this has occurred, been denied, or is pending. Additionally, the report states that "there are no treatment procedures pending", however, the FCE report from the day before states that surgery has been recommended. Since this is a contraindication for a tertiary pain program, this should have been addressed in the report also.

TDI-DWC has adopted the ODG treatment guidelines as the standard for workers' compensation claims. Based on ODG criteria and the records

submitted for review, the current request is deemed not medically reasonable and necessary at this time.

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)**