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Notice of Independent Review Decision

DATE OF REVIEW: 6/16/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a 10 sessions of a Chronic Pain Management Program 5 x Wk x 2 Wks (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. This reviewer has been in active practice 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 agrees with the previous adverse determination regarding the prospective medical necessity of a 10 sessions of a Chronic Pain Management Program 5 x Wk x 2 Wks (97799).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained a work related injury xx/xx/xx. She explained that she was reaching dumbbells when she felt a pull in her right shoulder Records prior to January 2009 (except for a designated doctor examination which gave a summary of records) were not available for review.

M.D. saw the patient 08/08/08 for a Designated Doctor Evaluation, finding her to be at MMI with a permanent impairment rating of eight percent, with diagnosis codes 723.9 and 959.2.

On 4/25/ 2008 the patient was seen by, MD, who diagnosed possible right cervical radiculopathy, right sternoclavicular joint traumatic arthritis. The patient was treated with a Medrol Dosepack. And given Celebrex. She was released to work with restrictions.

5-20-08 the patient received an injection into the right sternoclavicular joint, with good results. She remained on light duty.

On 8/12/2008 the patient received another injection to the right sternoclavicular joint. The claimant was continued at work with restrictions.

The patient requested a change of treating doctors in November 2008, changing from, MD , to, DC.

On 12/23/2008, PhD saw the patient for evaluation regarding her psychosocial mental status for purposes of further treatment planning. He recommended four individual psychotherapy sessions.

On 1-22-09, D.C., declared that the patient was not at MMI and that she needed evaluation and treatment for the cervical disc herniation. He recommended NCV/EMG and a consultation with a neurosurgeon. The patient was beyond the 90-day grace period to dispute issue of MMI.

, M.D. performed a Peer Review 12/18/2008, concluding that “this claimant appears to have sustained a cervical strain and a right shoulder strain. She has been treated with medications and injections with reported improvement On 8-8-08, the claimant underwent a Designated Doctor Evaluation. She was certified to be at MMI and was awarded 8% whole person

impairment for a minor injury.... There is no necessity for ongoing care or active treatment or further diagnostic testing.

On 01/23/09 a DWC request for a Letter of Clarification was submitted to Dr. by xxxxx, xxxxx. On 01/23/09 a letter was submitted by, xxxxx, disputing and requesting that a letter of clarification be submitted by Doctor xxxxx. On 02/09/09 Dr. submitted a letter of clarification, stating that "Dr. 's letter does not reflect any significant change with his exam as described in my report. The fact that the patient has reached MMI does not preclude administration of further treatment".

On 3/24/2009 , MD., evaluated the patient, and recommended conservative and symptomatic therapy, finding her not to be a surgical candidate.

On 7/10/2009 a request for chronic pain management was non-authorized. On 7/17/2009 the adverse decision was upheld on appeal. Among the reasons for non-authorization cited are the following:

There is no "adequate and thorough multidisciplinary evaluation" to determine the appropriateness of this request. There is no "physical exam that rules out conditions that require treatment prior to initiating the program" and, thus, is not an "adequate and thorough multidisciplinary evaluation" of this patient to determine the appropriateness of a chronic pain management as required by current guidelines.

On 8/20/2009 a request for chronic pain management and was non-authorized.

On 10/23/2009, behavioral testing was authorized as requested.

On 01/06/2010, M.D. saw the patient regarding the right shoulder pain. The handwritten note uses some abbreviations. Examination revealed tenderness at the right shoulder. There was tenderness at the medial end of the clavicle and at the sternoclavicular joint with possible subluxation. Right shoulder range of motion was limited beyond 70 degrees of abduction or 80 degrees of flexion, both worse than one year ago. Dr. prescribed Tylenol 500 milligrams prn, diclofenac 100 milligrams three times daily after meals, cyclobenzaprine tablets, and Voltaren gel. Dr. was hopeful that the main pain generators were at either end of the right clavicle. He noted that she should benefit from local injections (so far declined). He diagnosed sprain/strain of the right shoulder sternoclavicular joint and acromioclavicular joint. Dr. recommended return in one month

On a problem focused history and physical dated 2/23/2010, right shoulder flexion was 120 degrees, extension 30 degrees, abduction 135 degrees, abduction 30 degrees, internal rotation 60 degrees, and external rotation 40 degrees. The treatment plan was for chronic pain management, due to depression and anxiety. Also recommended were Psychological services for chronic pain management and pain medications per Dr..

Peer review was performed by Dr. 3/17/2010. Dr. again stated that there is not much one can offer this claimant other than maintenance care 2-3 times a year with one physician that can

provide medication management. The claimant is not a candidate for further physical therapy or chiropractic therapy. She has been denied Chronic Pain management via IRO.

On 4/27/2010 a handwritten note on a treatment plan mentioned referral to chronic pain management for depression treatment.

A physical performance evaluation was completed on 4 4/27/2010. Based upon the test results, a behavioral assessment evaluation was recommended. The behavioral evaluation was done 05/05/2010. No reports from imaging studies were submitted for review. Dr. referred to the MRI of the cervical spine 6-20-08 which showed central disc herniation/protrusion C5-C6 with minimal desiccation and narrowing of the intervertebral disc, with no significant canal stenosis or neural foraminal stenosis.

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

On May 5, 2010 Dr. documented in the Behavioral Evaluation and Updated Request for Services that the patient meets the criteria for the general use of multidisciplinary pain management program. However, according to the official disability guidelines, Integrated Treatment/ Disability Duration Guidelines pertaining to Chronic Pain, a prerequisite is that an adequate and thorough multidisciplinary evaluation has been made. This includes the following:

(3)(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....

Dr. was hopeful that the main pain generators were at either end of the right clavicle. He diagnosed sprain/strain of the right shoulder sternoclavicular joint and acromioclavicular joint. He mentioned that there may be subluxation at the sternoclavicular joint. The reviewer indicates no records of medical follow up pertaining to this matter were provided by any part to the review. Please note that the patient need not agree to have injections in order to qualify for an outpatient chronic pain management program. In general, an injured worker can forgo surgery, etc. and elect to participate in a chronic pain management or functional restoration program instead. However, all of the prerequisites have not been met in this case; therefore, the program is found to not be medically 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)**