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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program x 10 Sessions (80 hours)

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

M.D., Board Certified Orthopedic Surgeon

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

Chronic Pain Mgmt. Program, 04/24/09
Treatment Goals for chronic pain mgmt., Undated
Appeal – Authorization Request, 01/13/10, 01/15/10
Work Hardening Weekly Goal Sheet, 11/05/09; 11/12/09; 11/19/09
Operative Report, Dr. 07/24/08
Physical Performance Evaluation (PPE), 03/31/09
Cervical Spine X-Rays, 04/10/09
Chronic Pain Mgmt. Progress Report, Dr., 04/24/09
Office notes, Dr., 06/12/09, 06/29/09, 08/28/09, 09/26/09, 09/28/09
Cervical Spine X-Rays, 06/12/09
MRI Cervical Spine, 06/17/09
Prescription for PT 3x4, 06/26/09
Cervical Spine X-Rays, 08/28/09
Prescription for PT 1x1, Undated
Independent Medical Evaluation, Dr., 09/28/09
Work Hardening Progress Notes, 11/03/09, 11/12/09, 11/19/09
Treatment Progress Note, LPC, 11/04/09

Psychological Evaluation, 11/05/09

Physical Performance Evaluation (PPE), 11/12/09

Office note, 12/29/09

Adverse Determination Letters, 12/31/09, 1/13/10

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates: Pain --
Chronic pain programs (functional restoration programs)

PATIENT CLINICAL HISTORY SUMMARY

This claimant sustained a lifting injury on xx/xx/xx with a diagnosis of a C6-7 disc herniation with radiculopathy. The claimant underwent a decompression, discectomy and fusion with instrumentation of C6-7 on 07/24/08. The 04/24/09 record revealed the claimant had completed 6 sessions of individual psychotherapy and 10 days of in a chronic pain management program. The 06/12/09 record revealed an increase in neck pain with muscles spasms and stiffness. Cervical x-rays revealed postop findings. The 06/17/09 cervical MRI demonstrated C6-7 postop changes with a moderate diffuse C4-5 disc bulge with mild to moderate central canal stenosis but no definite spinal cord impingement.

A functional capacity evaluation completed on 09/08/09 documented the claimant's abilities at a light physical demand level (PDL) with a job requiring a heavy PDL. Consideration for job re-training was recommended. An Independent Medical Evaluation was completed on 09/28/09 and the examiner concluded that the claimant had not reached maximum medical improvement. The claimant entered into a work hardening program on 11/03/09. A psychological evaluation completed on 11/05/09 revealed a chronic pain disorder associated with both psychological factors and general medical condition; and a depressive disorder. The claimant completed 3 weeks of work hardening from 11/03/09 through 11/19/09 with no significant improvement. Weight tolerance remained unchanged at 15 pounds placing the claimant in the sedentary PDL with only slight improvement in endurance and work simulation. The claimant continued to have poor body mechanics and pace with constant pain behaviors. A letter of medical necessity dated 12/29/09 outlined that the claimant completed 10 sessions of work hardening but remained at a sedentary PDL. The claimant was noted to have continued significant barriers in functional abilities with a request for authorization of 10 sessions of chronic pain management.

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

This is a gentleman who has had neck pain since an injury in xxxx. He underwent a July 2008 C6-7 anterior cervical discectomy and fusion. Postoperatively, he continued to have pain complaints and underwent an MRI documenting postoperative changes. The record provided documents psychologic stresses and symptom fabrication. The records of Dr. in April of 2009 indicate he underwent six sessions of individual psychotherapy and 10 days of chronic pain management without improvement. He then had a 09/28/09 Chiropractic Independent Medical Evaluation and what appears to be two weeks of work hardening in November of 2009. Currently, a 10 session trial of chronic pain management has been requested. ODG guidelines document the use of chronic pain management and functional restoration in patients who have chronic pain with incomplete improvement following treatment. In this case, this claimant has already had chronic pain management without improvement, and there is no documentation in the medical record that a new injury was sustained or a new surgical intervention occurred or that there was any change in his diagnostic testing after the prior pain management treatment. The claimant has also had work hardening and multiple other treatments without any improvement.

While ODG guidelines document the use of a chronic pain program, the results of cervical spine pain programs appear to be less efficacious than the results of lumbar spine chronic pain programs. In this case, the claimant has already gone through a full program without improvement. There is no evidence in the medical record of intervening surgery or other change in his underlying condition. The reviewer finds that medical necessity does not exist for Chronic Pain Management Program x 10 Sessions (80 hours).

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)