=SENT VIA EMAIL OR FAX ON
Mar/02/2010

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/25/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management 5 X 2

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 12/3/09 and 12/30/09
AR-CMI 2/15/10
6/18/08 thru 1/6/10
Dr. 12/4/09
Dr. 8/5/09
DDE 6/23/09
FCE 6/23/09
PPT 6/23/09
Dr. 10/23/08
MRI 5/6/08
Dr. 6/18/08

PATIENT CLINICAL HISTORY SUMMARY
This is a man reportedly injured on xx/xx/xx when he developed pain at work. He had been diagnosed with lumbar strain and a radiculopathy. The MRI done in 5/08, 2 months post injury) showed multiple level facet changes and disc changes without any nerve root compressions. He had back pain down the leg, but I did not see it described in a dermatomal pattern as required by the ODG for a radiculopathy and ESIs. He had 2 EMGs in 2009 where the diagnosis of a radiculopathy was made on the soft signs of polyphasic potentials and insertional and prolonged latencies, yet there was also a polyneuropathy. ESIs were therefore not likely approved for these reasons. There were different reports on the physical finding on the presence or absence of knee and ankle jerks and sensory abnormalities. He had a facet synovitis described on an ultrasound. The AIUM, the generally accepted pseudoboard in ultrasound, discounts these spinal studies as experimental. The physical examinations showed local lumbar tenderness. There are FCEs from 2008 and early 2009 mentioned, but not presented. The FCE done in June 2009 showed him to be able to perform at a medium PDL(or greater) and met the requirements of laborer. (“”…Mr. occupation as a Laborer in the medium strength category. Therefore, Mr. meets these strength requirements and may return to work as a laborer.” Further “Mr. is capable of assuming a position in the heavy strength category.”) The FCE from 11/09 reported him at a light sedentary level. Graphs of lifting and knee motion show levels of variance questioning validity. Dr. noted he attempted to work in April 2009, but the employer would not comply with restrictions. He is on Celebrex, but no opiates. He is not working and has no definite plans for retraining. He had completed 10 sessions of a pain program. He has a BAI of 10 and a BDI of 8, both normal. In the letter (11/25/09) requesting an extension of the program, both Dr. and Dr. wrote of improved pain coping and function, but with residual elevated pain levels and poor insight. His Tampa Kinesiophobia “a score that continues to fall in the elevated range.”

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
First, he has back pain, but not clearly a radiculopathy as defined in the ODG and AMA Guides. The facet and disc changes probably predated the original injury. He was previously accepted to the pain program, but the question is the need for the extension for 10 more sessions. This is addressed in criteria 10. He apparently complied with the program. The question then is “significant efficacy.” The FCE from June to November 2009 showed a reduction in the PDL. Since it was not the same test, this measurement may not be identical. In essence, the need for the extension is to overcome the kinesiophobia and the problems with the insight to the pain. The reviewer did not see any objective improvement in the Kinesiophobia score. The goals in the 11/25/09 request describe subjective improvement in coping skills and objective improvement in strength and stamina. It did not directly address the Kinesiophobia issues. . Dr. noted it did not improve with the first 10 sessions; the reviewer is not sure how it will improve with the second. The same is the lack of insight with the second 10 sessions. Based on a careful review of all medical records, the reviewer’s medical assessment is that the second series of treatments is not medically necessary.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH

ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)