I-Decisions Inc.

An Independent Review Organization
5501 A Balcones Drive, #264
Austin, TX 78731
Phone: (512) 394-8504
Fax: (207) 470-1032
Email: manager@i-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
97799 Chronic Pain Management Program x 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:

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates, Pain Chapter, Chronic Pain Management Program (Functional Restoration Program)
Peer Review, Dr.; 1/27/10
Peer Review, PhD; 1/12/10
Accident & Injury Rehab: Mental Health Evaluation 11/11/09, Treatment Plan 11/11/09, FCE 1/30/08, FCE 10/2/07
D.C.; 11/17/09 request authorization for pain management, Letter to Dr., Impairment Evaluation 5/15/08, office note 8/13/07
Dr.; office notes 3/6/08, 10/22/07, 12/10/07; 9/10/07 letter
Dr.; office notes 6/29/09, 4/13/09, 11/12/08, 6/3/08, 3/3/08
Work Hardening Progress note, 4/28/08
Dr. ; Office notes, 10/9/07, 8/14/07, 9/4/07
Diagnostics: 2/14/08 CT/Myelogram Lumbar, 5/8/07 MRI lumbar, 10/19/07 MRI lumbar, 3/11/08 bilateral lower extremities electrodiagnostic studies, 1/24/01 MRI lumbar
Dr.; Office note/letter 10/9/07
Dr.; DDE 2/28/08
IRO Summary 2/9/10, IRO Notice of Decision 11/13/07, IRO Reviewer Report 11/9/07 Independent Review 11/21/07
Member Profile Report and Claim History Report 2/4/10
Associate Statement 3/21/07
Phone call documentation Physical Therapy/Dr., undated
Physical Therapy Today; Initial Evaluation 4/4/07, Daily Notes 8/27/07, 8/29/07, 9/4/07, 9/7/07, 9/11/07, 9/14/07, 9/17/07, 9/19/07
Dr., Psychological Assessment dated 10/2/07, Progress Note 10/15/07

PATIENT CLINICAL HISTORY SUMMARY
This male has treated for low back pain. He sustained an injury to his back on x/xx/xx while lifting a large tire. He has had multiple MRI studies, the last on 10/19/07 documenting mild degenerative changes at L4-5 and L5-S1, and a small right posterior paracentral disc protrusion at L5-S1. A 2/14/08 CT/Myelogram documented anterior osteophyte formation, disc space narrowing, and vacuum phenomenon at T12-L1; very mild posterior disc bulge T12-L1 minimally effacing the ventral subarachnoid space; there was no evidence of nerve root impingement and the remaining disc spaces were unremarkable. An electrodiagnostic study done on 3/11/08 was negative for findings of neuropathy, radiculopathy, or plexopathy in the bilateral lower extremities; of note is documentation by the provider that the claimant was heavily medicated and had difficulty with simple commands and answering simple questions.

Treatment to date has included 10 sessions of active physical therapy in 2007, 10 days of work hardening in 2008 (not completed as he was a possible surgical candidate though surgery never was done), psychotherapy in 2008, and medications to include OxyContin 40 mg, Oxy IR 5 mg, and Clonazepam 1.5 mg. In 2007, L4-5 and L5-S1 facet median nerve blocks were recommended however; upon peer review it was found that they were not medically necessary.

The most recent knowledge with regard to his functional level is documented in a Functional Capacity Evaluation dated 1/30/08; at that time he was functioning at a medium physical demand level. The claimant's prior job requires a heavy physical demand level. In May of 2008, there was an evaluation that documented a 5 percent impairment rating with notation that maximum medical improvement had been achieved. Currently, there is a request for authorization of a chronic pain management program, 80 hours have been requested. The claimant had a mental health evaluation done on 11/11/09 which documented that he had significant distress and impairment in independent, occupational, and other areas of function from psychological, physical, and psychosocial symptoms. The evaluator indicated that the claimant would be an appropriate candidate and would benefit from treatment in a chronic pain management program. There is not documentation of the claimant's current clinical status and or his functional abilities. This request has been through the Peer Review process on two different occasions and has not been recommended as medically necessary with notation of red flags in claimant presentation and in the case, as well as a lack of information with regard to the past work hardening program that the claimant attended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
Review of the records provided supports the claimant is a gentleman who reported back pain, lumbar sprain, status post lifting episode xx/xx/xx. Treated in the past with psychotherapy in April 2008. Active therapy in 2007, OxyContin, OxyIR, clonazepam, epidural steroid injection, work hardening 10 days in 2008. Previously, a functional capacity evaluation on 01/30/08 showed capabilities consistent with a medium demand level of work. CT myelogram showed mild degenerative changes, otherwise unremarkable, no fracture. The electrodiagnostic study was negative for neuropathy, radiculopathy, or plexopathy.

Mental health evaluation in November 2009 noted previous low back injury, with termination of employment in 2006 for excessive leave of absence; he was hired back at a later date. It was documented that he had significant distress, impairment and problem areas in functional, psychological, physical, psychosocial symptoms. The conclusion of the examiner was that he would benefit from treatment in a chronic pain program. The requested duration of the program was 80 hours, which would be a trial of 10 visits.

The patient's abilities were documented to be in the medium physical demand level. The request was denied on a peer review due to failure to have recent treatment with physical therapy or anti-inflammatory medications on 01/12/10 and was denied on 01/27/10 as prior work hardening documentation was not provided.

The work hardening program report does not include his intake form and his outtake form nor

his response to work hardening over 10 days in 2008; and there is no comparison evaluation documented. I would agree with the previous letters of denial that without additional records, the medical necessity is not substantiated at this time. Based on review of the records provided and the ODG criteria not being satisfied, the reviewer finds that medical necessity does not exist at this time for 97799 Chronic Pain Management Program x 80 Hours.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates, Pain Chapter, Chronic Pain Management Program (Functional Restoration 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

[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)