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**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:**

May/19/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Chronic Pain Management 5x2 80 hrs 97799

**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**

Official Disability Guidelines Treatment in Workers' Compensation, Chapter: Pain  
xxxxxx, 3/15/10, 3/29/10  
Office notes, Dr., 11/03/09, 11/04/09, 11/18/09, 03/05/10  
PT initial evaluation, 11/03/09  
Mental Health Evaluation, 11/04/09  
Letter, Dr., 02/04/10  
xxxxxx, 03/09/10  
Office note, Dr., 03/09/10, 03/30/10  
Reconsideration letter, Dr., 03/16/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a worker who was injured in xx/xxxx when she slipped and fell on a wet floor with reported neck, back and shoulder injuries. Non-operative treatment included four weeks of reconditioning ending in September 2009. A cervical MRI showed central disc protrusions at C5-6 and an EMG showed cervical radiculopathy. The claimant has been diagnosed with chronic cervical pain, chronic lumbar pain and chronic bilateral shoulder pain. A functional capacity evaluation performed on 03/09/10 identified range of motion and strength deficits. The records indicated that the claimant did not appear to have a surgically treatable option. A chronic pain management/functional restoration program was recommended.

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

This review is of the medical necessity of chronic pain management five times a week for two weeks, 80 hours. Review of the medical record provided shows the patient reported an injury 07/18/09. There is MRI that showed disc protrusions, and there was radicular irritation on EMG. She had 4 weeks of reconditioning in September 2009 and was taking hydrocodone. On the Beck Depression Inventory there was evidence of severe depressive symptoms.

A Mental health evaluation completed on 07/04/09 recommended an interdisciplinary rehab program based on functional restoration. Dr. evaluated the patient on 11/04/09 and recommended the Pride Program. On 03/05/10 Dr. noted the patient was highly motivated to return to work and light duty work was unavailable. An FCE that was completed on 03/09/10 showed that the results were valid and a functional restoration program was recommended as the patient did not meet lifting requirements for her job. She saw Dr. 03/09/10 who felt the patient had reliable consistency of effort at this time and recommended the Pride Program. The mental health evaluation on 11/04/09 showed a pain disorder, major depressive disorder, and generalized anxiety disorder.

I have considered the evidence-based ODG guidelines, and have reviewed the medical records that were provided and have concluded that there is a medical necessity for chronic pain management program five times a week for two weeks for 80 hours. This is consistent with evidence based medicine, ODG guidelines. The patient has chronic pain since her reported injury in xx/xxxx. She has utilized medications, physical therapy, conditioning. FCE showed a valid attempt and inability to return to work at prior level. Previous treatment options have been unsuccessful and there is no surgery planned. The patient has had a mental health evaluation that recommended an interdisciplinary rehab program. The patient was exhibiting motivation to change and return to work and is no more than two years out from the injury. There is not evidence of a negative predictor of success at this time. The reviewer finds that medical necessity exists for Chronic Pain Management 5x2 80 hrs 97799.

**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)