



MedHealth Review, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: 5/11/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a pain management program 5 x Wk x 2 Wks – lumbar (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 performs this type of service in active practice and has been practicing 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 pain management program 5 x Wk x 2 Wks – lumbar (97799).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: xxxxxx

These records consist of the following (duplicate records are only listed from one source): Records reviewed from xxxxx: Pre-auth request – 3/15/10 & 3/30/10;, Ph.D., LPC xxxxx CPM Eval – 3/9/10,

Reconsideration request – 3/30/10; Treatment Goals; New Patient Questionnaire – 3/9/10; Initial Program Eval – 3/9/10; DO Note – 3/9/10.

Records reviewed from xxxxx were all duplicates from xxxxxx

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the available medical information, this man was originally injured xx/xx/xx while lifting and noting sharp lower back pain. Following a failure to respond to non-surgical treatment, he underwent a lumbar disk surgery 08/13/09, which was followed by postsurgical therapy and rehabilitation. The patient has remained symptomatic and continues to require regular narcotic medication. As his physical demand level testing indicates function at lower than his pre-injury work level, a multidisciplinary chronic pain management program has been requested but denied on both original, 03/18/10, and on reconsideration, 04/07/10.

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

Utilizing the standards and criteria of the *ODG* for the multidisciplinary chronic pain management program, there is identified within the documentation indicating that while this individual has experienced continuing pain symptoms subsequent to his surgery and post-surgery treatment, there has been minimal to little indication of patient's objective progress, response to available treatment, and apparent failure to follow through on treatments that he has received. This is noted in the initial program evaluation 03/09/10, where the statement under "Status" is, The patient, "has demonstrated significant regression with significant deficits throughout the left lower extremity and the lumbar musculature noted by antalgic gait and intense complaint of pain. At this time, (he)... has decreases in active range of motion, lifting capacity, and strength within the lumbar region and his left lower extremity. Due to these limitations, based on his job description, he is limited in job performance capacity at CTJ Maintenance."

Additionally, in the "Treatment Goals" noted in the pain management program request, it is indicated that the patient's current status includes the following areas of failure to respond and to take initiative to do the necessary postsurgical activities and exercises, noting:

- Spends about eight hours combined per day watching television.
- Relies on others for help with most chores.
- Socialization – none.
- General exercise – none.
- Hobbies – none.

A key element in the *ODG* criteria for participation in a chronic pain management program is the indicated potential that patient will obtain significant benefit from participation in this program. At this point in time, the patient appears to be making little or no effort in his postsurgical rehabilitation program to indicate the likelihood that there will be any benefit from participation in such a structured program; therefore the requested service is not medically necessary.

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)