



Notice of Independent Review Decision

DATE OF REVIEW: 4/27/10

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management x10 sessions (5x2) (CPT 97799).

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

Texas board certified anesthesiologist with added qualifications in pain medicine.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The request for 10 Chronic Pain Management x10 sessions (5x2) (CPT 97799).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice to of Case Assignment dated 4/9/10.

- Request Letter dated 4/9/10.
- IRO Request Form dated 4/7/10.
- Final Peer Review Report dated 3/24/10, 3/4/10.
- Designated Doctor Examination Report/Letter dated 3/22/10.
- Report of Medical Evaluation dated 3/22/10.
- Texas Workers' Compensation Work Status Report dated 3/22/10.
- Office Visit Note dated 3/17/10, 2/24/10, 1/21/10.
- Fax Cover Sheet/Note dated 3/17/10.
- Request for Preauthorization, Concurrent Review, and Voluntary Certification per TWCC Adopted Amended Rule Form dated 3/17/10, 2/26/10.
- Request for Reconsideration dated 3/17/10.
- Pre-Authorization Request dated 2/26/10.
- Work Capacity Evaluation Report dated 2/16/10.
- Mental Health Evaluation Report dated 2/6/10.
- Orthopedic Report dated 5/6/08.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: xx

Date of Injury: xx/xx/xx

Mechanism of Injury: A slip and fall, resulting in an injury to the lumbar spine and right shoulder.

Diagnosis: Lumbar intervertebral disc derangement and internal derangement of the right shoulder.

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

The patient with a date of injury of xx/xx/xx. The mechanism of injury was a slip and fall, on a patch of ice while walking into a freezer. The patient sustained an injury to the lumbar spine and the right shoulder. The diagnoses were lumbar disc displacement and internal derangement of the right shoulder. There was treatment rendered consisting of medications, physical therapy (PT), arthroscopic shoulder surgery, and medication management. There was indication that the patient was on medications for her back pain. Other than medications, the patient had received no documented treatment for her low back pain (LBP). The magnetic resonance imaging (MRI) of the lumbar spine was notable for an L5-S1 left paracentral herniated nucleus pulposus (HNP), with left L5 nerve impingement. The patient was seen and recommended to undergo a chronic pain management program (CPMP), for 10 sessions. There was noted a Beck anxiety inventory (BAI) of 31, a

Beck Depression Inventory (BDI) of 35, a Global Assessment of Functioning (GAF) of 57, Pain and Impairment Relationship Scale (PAIRS) of 80, and a Oswestry of 52. Her back pain was noted to be an 8/10.

Criteria for the general use of multidisciplinary pain management programs includes the following : “Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances: (1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (d) Failure to restore pre-injury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention)...; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function. (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.”

In this case there is noted to be an L5S1 HNP, with on going back pain. There has been no indication of treatment provided for this problem. Therefore there has not been a failure of conservative measures to treat all the injuries that have come about from the fall. Based on this, the request for Chronic Pain Management x10 sessions (5x2) (CPT 97799) is premature at this time and the determination of not medically necessary is supported.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010,
Pain--Chronic pain programs (functional restoration programs).

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).