Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management 8 hours per day for 5 days per week for 2 weeks 97799

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management

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
xxxxxx, Utilization Review Decision Letters, 2/2/10, 4/7/10
xxxxx 2/2/10, 2/22/10, 1/25/10
xxxxx 2/23/10, 1/25/10, 1/27/10, 8/3/09
xxxxxx 1/5/10, 7/2/09, 9/23/09, 8/19/09,
10/5/07, 9/4/07, 8/21/07, 5/20/09, 6/16/09, 7/22/09, 9/24/09, 10/28/09,
11/25/09, 12/23/09, 1/20/10, 2/17/10
BHI 7/22/09, 7/2/09
M.D. 4/28/09, 1/14/09, 4/18/09, 8/10/09, 9/22/09, 11/20/09
Initial Diagnostic Screening Update 9/16/09, 8/3/09
xxxxx 8/5/09
Diagnostic 3/6/09
xxxxxx. 8/12/09
8/12/09
Treatment Progress Note 11/6/09, 11/18/09, 11/25/09
ODG-TWC

PATIENT CLINICAL HISTORY SUMMARY
This is a woman who was injured in xx/xxxx. She underwent a L5/S1 fusion in 2002, but had ongoing back pain. She failed to improve with ESIs and SI injections. She had an MRI in 2009 that showed an L4/5 disc protrusion and an EMG that showed chronic left L5/S1 radiculopathy. She has had several FCEs in the past year where she functioned at a sedentary level. Her pain grade had been recently at a 6, but as high as an 8. She used to use 3 hydrocodone a day, but apparently is up to 4 a day. Ms is following her. She described the claimant as having a perception that her condition is “extremely severe.” She had some minor gains in pain with psychotherapy and the request now is for a pain program. She is noted to have major depression and functional issues. The request noted that although her injury was more than x years ago, “the critical period for successful program intervention is immediate.”

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

While the records indicate this claimant has chronic pain and there are no other treatment options remaining, the Official Disability Guidelines for admission to a pain program are very restrictive for pain which has lasted longer than 2 years in duration. This claimant is 10 years post injury and 8 since surgery. She also has several negative predictors including a "negative outlook about future employment." The arguments provided state that she will return to work at a light PDL after treatment. She has ongoing depression. The ODG will permit a chronic pain program in "long duration" patients when "the outcomes for the necessity of use (are) clearly identified…" The records provided gave goals of reduced pain, improved stamina to a light PDL work position, and improved coping skills. However, they are generalized and vague. The claimant does not meet the criteria for participation in a chronic pain program. The guidelines are not satisfied. The reviewer finds that medical necessity does not exist for Chronic Pain Management 8 hours per day for 5 days per week for 2 weeks 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

[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)