The DYLL REVIEW
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25 Highland Park Village #100-177 Dallas TX 75205
Phone: 888-950-4333 Fax: 888-9504-443

Notice of Independent Review Decision

DATE OF REVIEW: 9/17/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of 80 hours of chronic pain management program

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

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.

Based on review of the noted documentation from the requester and the pre-authorization company the pre-authorization denial is recommended to be overturned.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 17 page fax 9/3/2010 Texas Department of Insurance IRO Request, 42 page fax 9/8/2010, 22 page fax 9/10/2010

The IRO case concerns a prospective pre-authorization request for 80 hours of a daily chronic pain management program. The pre-authorization request was denied on both the initial and reconsideration by the based on the 2 dates of August 3, 2010 and August 13, 2010. The provided records from in relationship to the denial as well as the original request from of, M.D., Medical Director, were provided for documentation of this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical history summary indicated that the patient is a female with date of injury of xx/xx/xx. There was history of a right wrist, shoulder, upper extremity, and neck pain symptoms following a reported electrical shock. Treatment had included only conservative treatment. Carpal tunnel syndrome releases on the right were found medically necessary December 9, 2009, and May 3, 2010, but surgery was not pre-

authorized. Current medications include Lyrica and Ultram. The requested pre-authorization for an initial 80 hours of an interdisciplinary chronic pain rehabilitation program, CPT code 97799.

The original denial and reconsideration denial were based on the ODG. The rationale indicated that the necessity for this program was not medically necessary as there had been no "thorough behavioral, psychological examination to provide a reasonable manifest explanation for the etiology and maintenance of patient's clinical problems" (i.e. pain, pain complaint, behavior, and disability or to provide a "cogent explanation for the identified complaints and dysfunction.") The medical information and reply from the requester indicated that the appropriate documentation had been supplied both in the original request for pre-authorization, July 28, 2010 and the request for reconsidered of August 6, 2010 in extensive documentation by M.D.

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

Based on the ODG the patient does have sufficient support to meet the criteria indicated in the ODG for an initial 80 hours of a chronic outpatient pain rehabilitation program to complete the patient's medical care.

Citation: ODG, Pain Chapter. Criteria for the General Use of Multi-Disciplinary Pain Management Programs.

The ODG indicates that "outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

$ 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:

a. Excessive dependance on health care providers, spouse or family.
b. Secondary physical decondition due to disease and/or fear avoidance of physical activity due to pain.
c. Withdrawal from social activities or normal contact with others including work, recreation, or other social contacts.
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 incidence, including anxiety, fear avoidance, depression, sleep disorders, or non-organic illness behaviors (with a reasonable probability to respond to treatment intervention)
f. Diagnosis is not primarily a personality disorder or psychological condition without a physical component.
g. Evidence of continued use of prescription pain medications without evidence of improvement in pain or function.

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- Previous method of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.
- Adequate and thorough multidisciplinary evaluation has been made.
- If a goal of treatment is to prevent or avoid controversial or optional surgery a trial of 10 visits may be implemented to assess whether surgery may be avoided.
- If a primary reason for treatment in the program is addressing possible substance abuse issues at evaluation with an addiction clinician may be indicated on entering the program.
- A treatment plan should be presented with specifics for treatment of identified problems and outcomes that will follow.
- Documentation that the patient has motivation to change.
- Negative predictors of success should be identified and, if present, the pre-program goals should indicate how they will be addressed.
- If a program is planned for a patient that has been continuously disabled for greater than 24 months the outcomes for the necessity of use should be clearly identified.
- Treatment is not suggested for longer than two weeks without evidence of compliance and significant demonstrated efficacy documented by subjective and objective gains.
- Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures, and stage of treatment must be made available upon request, at least on a bi-weekly basis during the course of treatment program.
- Total treatment duration should generally not exceed 20 full day (160 hours) sessions.
- At the conclusion and subsequently neither re-enrollment in repetition of the same or similar rehabilitation programs is medically warranted for the same condition or injury.
- Suggestions for treatment post program should be well documented and provided to the referral physician.
- Post treatment medication management is particularly important.

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Considering the ODG provided criteria as outlined above, review of the documentation from the requestor at and in consideration of the denial rationale provided by the pre-authorization company it is my opinion that the ODG Guidelines have been met and an overturn of the pre-authorization denials 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 & 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)**