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Notice of Independent Review Decision

DATE OF REVIEW: 02/11/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten day chronic pain management program for the lumbar spine

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

Board Certified in Orthopedic Surgery

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)

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.

Ten day chronic pain management program for the lumbar spine - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 08/18/09, 10/06/09, 11/09/09, 12/08/09, 01/11/10, 01/27/10, 02/16/10, 04/05/10, 05/18/10, 06/28/10, 08/16/10, 11/03/10, and 12/13/10
A lumbar myelogram CT scan dated 09/09/09
X-rays of the lumbar spine dated 11/05/09
Chest x-rays dated 01/14/10
An operative report dated 01/29/10
Chest and lumbar spine x-rays dated 01/29/10
A discharge summary dated 01/31/10
A letter of medical necessity dated 10/27/10
A preauthorization approval form dated 11/02/10
Psychosocial evaluations dated 11/03/10 and 12/13/10
Physical Performance Evaluations (PPEs) dated 11/03/10 and 12/13/10
A letter of preauthorization, according to the Official Disability Guidelines (ODG) dated 11/03/10
A letter of preauthorization according to the ODG, dated 11/09/10
A letter of preauthorization request for 10 sessions of a chronic pain management program dated 12/13/10
A letter of denial for a pain management program according to the ODG, dated 12/17/10
A CT scan of the lumbar spine dated 01/05/11
A preauthorization request appeal dated 01/06/11
A Notice of Reconsideration and denial, according to the ODG, dated 01/11/11
A letter of appeal to IRO dated 01/25/11
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 08/18/09, x-rays taken of the lumbar spine that showed some change in the fixation from a lumbar laminectomy and fusion on 07/01/98. Dr recommended a lumbar myelogram/CT scan, Lyrica, Restoril, Lidoderm patches, Norco, and Soma. A lumbar myelogram CT scan on 09/09/09 showed central canal stenosis and mild retrolisthesis at L2-L3, a previous fusion at L3-S1, slight retrolisthesis of L1-L2, and disc protrusions at T11-T12 and T12-L1. A lumbar ESI was performed 11/05/09. On 01/29/10,performed lumbar spine surgery. On 02/16/10, recommended continuation of a bone stimulator and lumbar brace. On 06/28/10, recommended Neurontin, Rybix, a lumbar wrap, TENS unit, and continued physical therapy. On 11/03/10 and 12/13/10, requested 10 sessions of a chronic pain management program. Based on a PPE with Therapist on 12/13/10, it was felt he was a good candidate for the pain management program. On 12/17/10, Dr. wrote a letter of denial for the pain management program. A CT scan of the lumbar spine interpreted on 01/05/11 showed solid fusions at L2-S1, postoperative fluid collection at L4-L5, and disc protrusions at T12-L1, L1-L2, and L2-L3. On 01/06/11, the patient wrote a letter of appeal for the pain management program. On 01/11/11, Dr wrote a letter of denial for the 10 day chronic pain management program. On 01/25/11, Dr. wrote a letter of appeal to the IRO for the pain management program.

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

This patient has had chronic pain, never having returned to work or functional life since 1997, according to the documentation provided at this time. The documentation does not support the need for a chronic pain program. Although his pain has been long standing, there is no evidence that the patient has motivation to change and is willing to change his medication regimen. There have been significant negative predictors of success, including the length of time of disability. Since he has been continuously disabled for greater than 24 months, the ODG has been unable to sufficiently demonstrate that a chronic pain management program increases a patient's ability to return to work. The outcomes from the necessity of use have not been identified. There is no evidence that the patient has had a psychological evaluation that would indicate he would recover from his chronic pain or even have significant decrease that has been advocated by the treating providers. The patient does not meet the criteria for the general use of multidisciplinary pain management programs as listed in the ODG, chapter on the treatment of chronic pain. Therefore, the requested 10 days of a chronic pain management program for the lumbar spine is neither reasonable nor necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE**
- ☐ **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)