Core 400 LLC

An Independent Review Organization
209 Finn St
Lakeway, TX 78734
Phone: (512) 772-2865
Fax: (530) 687-8368
Email: manager@core400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/31/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic pain management program five times a week for two weeks

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Workers' Comp Services, 12/7/10, 12/20/10
Official Disability Guidelines, Chapter: Pain, Chronic Pain Programs
8/31/10 to 1/4/11
Rehab Center 11/23/10 to 12/13/10
Headache Institute 1/8/08 to 1/22/08
M.D., P.A. 8/1/07 to 9/17/07
10/18/07
History and Physicals 6/11/07
Health Systems 6/11/07
Imaging 7/23/07 to 8/13/07
Neurological Surgeons 6/11/07
M.D. 8/24/07 to 6/9/08

PATIENT CLINICAL HISTORY SUMMARY
This is a man injured in accident in xx//xx. He sustained neck, back and shoulder injuries. He had a shoulder arthroscopy in 10/07 for impingement. He continued to have pain. He reportedly had an FCE in 2008 that showed him to meet his job requirements, but remained symptomatic. The MRI and CT studies showed disc bulges and C6/7 and foraminal hypertrophy at C5/6, tendinosis in the left shoulder, and degenerative changes in the lumbar spine. Dr. felt he had chronic myofascial pain with spinal strains, facet hypertrophy and

degenerative changes. Dr. advised (8/31/10) a pain program, and (11/9/10) work hardening. Dr. noted that he had moderately reduced function on the FCEs of 9/2/10 and 11/12/10. He attributed this to a leg injury in xx/xx in both reports and advised a pain program. I presume he meant the xx/xx injury as I am reviewing for the xx/xx injury only. Ms performed a psychological screen. She reported his goals were to “fix his neck, reduce his headaches,” resume some normalcy and return to work.

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

Dr., and Ms argue for his entrance into a pain program. They cite the goals of reducing pain and returning him to work. The ODG has special caution for people referred for pain program more than 24 post injury. The injury is now nearly 4 years old. The ODG states there are additional criteria when there has been an interval of more than 24 months after the injury. In this patient’s case, “the outcomes for the necessity” are not “clearly identified…” as required by ODG. While this does not preclude the patient “from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population,” there was no evidence provided that this pain program has been effective in patients with pain lasting more than 24 months in duration. It is unclear if the patient is willing or motivated. The goals cited are to “fix his neck.” Unfortunately, I did not find the necessary information to justify the medical necessity for admission to the program based upon the records reviewed. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The reviewer finds no medical necessity at this time for Chronic pain management program five times a week for two weeks.

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)