COMPPARTNERS

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Notice of Independent Review Decision

**DATE OF REVIEW: 12/30/10**

**IRO CASE #:** **NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Determine the appropriateness of the previously denied request for Chronic Pain Management Program – 10 sessions (CPT 97799).

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
**Texas licensed pain management physician**

**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.

The previously denied request for Chronic Pain Management Program – 10 sessions (CPT 97799).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. Authorization Request Letter dated 12/17/10.
2. Preauthorization Determination Report dated 11/4/10, 10/7/10.
3. Determination Notification Report dated 11/3/10, 10/6/10
4. Reconsideration Preauthorization Request dated 10/27/10.
5. Functional Capacity Evaluation Detailed Narrative Report dated 10/22/10, 8/11/10.

6. Functional Capacity Evaluation Report dated 10/22/10, 8/3/10.
7. Functional Capacity Evaluation Summary Report/Letter dated 10/22/10, 8/11/10.
8. Environmental Intervention dated 10/6/10.
9. Examination Report dated 10/1/10.
10. Pre-Authorization Request dated 10/1/10.
11. Patient Face Sheet dated 9/20/10.
12. Psychological Testing Results dated 9/2/10.
13. Lumbar Spine MRI Report dated 5/20/10.
14. Cervical Spine MRI Report dated 4/29/10.
15. Left Shoulder MRI Report dated 4/29/10.
16. Initial Behavioral Medicine Consultation Report dated 10/23/09.
17. Interdisciplinary Pain Treatment Components (unspecified date).
18. Chronic Pain Management Program Design (unspecified date).
19. Chronic Pain Management Program Day Treatment Design (unspecified date).
20. Prescription (unspecified date).
21. There were no guidelines provided by the URA for this referral.

**PATIENT CLINICAL HISTORY (SUMMARY):**
**Age:**
**Gender:**
**Date of Injury: xx/xx/xx**
**Mechanism of Injury: He was struck by a semi-tractor trailer on the left side.**

**Diagnosis: Neck strain/sprain, thoracic strain/sprain, shoulder sprain, and possible brachial neuritis.**

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

This male sustained an industrial injury on xx/xx/xx while performing usual duties as a xx. He was struck by a semi-tractor trailer on the left side and sustained multiple injuries. He was seen at local emergency department, underwent diagnostic X-rays, and received intramuscular analgesic medication. A head computed tomography (CT), abdominal CT, and pelvis CT were reportedly normal. Subsequently, cervical spine magnetic resonance imaging (MRI) scan (noncontrast) on 4/29/10 demonstrated C3-4 right paracentral disk protrusion. A left shoulder MRI scan on 4/29/10 demonstrated supraspinatus tendinopathy without evidence of a tear and mild acromioclavicular joint osteoarthritis. Additionally, on 4/29/10, the thoracic spine MRI scan demonstrated mild central canal stenosis at T10-11. A 5/20/10 lumbar MRI scan was demonstrating multilevel degenerative changes and disk bulging at L3-4, L4-5, and L5-S1 levels. There was moderate facet joint hypertrophy at L3-4, L4-5, and L5-S1 levels and early spinal stenosis at L3-4 and L4-5. The claimant completed 12 sessions of physical therapy (PT) and 12 sessions of individual psychotherapy with 3 sessions of biofeedback. He underwent an 8/11/10 functional capacity evaluation, which demonstrated invalid findings. This was repeated on 10/22/10 and was now demonstrating 83% validity criteria and only one or five Waddell signs. On 9/3/10, psychological testing was performed. A previous request for

chronic pain management program, 10 sessions, was non-authorized and now was at the independent review level. The denial is upheld with regard to the requested 10 additional chronic pain management program treatments, because this request does not satisfy ODG criteria. The claimant has not exhausted all known treatment available for this condition. This would include invasive pain management procedures. The ODG states, “Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result significant clinical improvement.” Although the claimant has received PT and psychotherapy sessions, there was no documented evidence that the claimant had undergone any invasive pain management procedures that would have the potential for providing therapeutic benefit with improved function of the claimant. Therefore, the 10 additional chronic pain management program treatments (CPT 97799) would not be considered medically necessary and the previous adverse determination is upheld.

**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.

**X** ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES, 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).