

SENT VIA EMAIL OR FAX ON
Jul/28/2011

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/27/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of chronic pain management for lumbar spine

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

MD board certified anesthesiology/pain management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

1. Utilization review determination 06/14/11 regarding non-certification 80 additional hours (10 sessions) chronic pain management for lumbar spine
2. Reconsideration/appeal of adverse determination 07/05/11 non-certification 80 additional hours (10 sessions) chronic pain management for lumbar spine
3. Injury One request for 10 additional days of chronic pain management program 06/09/11
4. Injury One reconsideration request for 10 additional days of chronic pain management program 06/28/11
5. Patient face sheet
6. Reassessment for chronic pain management program continuation 05/26/11
7. Physical performance evaluation 05/25/11
8. Functional capacity evaluation 05/17/11

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a female whose date of injury is xx/xx/xx. Records indicate she was performing her duties as a and preparing fish when a coworker opened the freezer door hitting her back and driving her forward. While falling the injured employee reportedly caught herself from falling by catching herself on a table. MRI of the lumbar spine revealed a broad

based posterior disc protrusion at L4-5 with mild facet hypertrophy bilaterally. She was treated with physical therapy, cervical epidural steroid injection, work hardening, medications and individual psychotherapy. The injured employee also has completed 10 days of an interdisciplinary chronic pain management program (CPMP). Her injury related medications were noted to include Hydrocodone 7.5/500mg, Mobic 15mg, Flexeril 10mg, Risperdal 3mg, Benadryl 40mg and Citalopram 40mg. It was noted that titration of Hydrocodone and Flexeril would be a focus of the pain management program. Per the request for 10 additional days of a chronic pain management program it was noted the injured employee maintained her pain level despite the intense nature of the program. She also noted reduction in irritability and anxiety. Noting that the injured employee had demonstrated functional improvement, which was asserted as not only improvement of function but maintenance of function that would otherwise deteriorate, and further noting that the injured employee had not met her targeted reduction of 75% in every active symptom it was recommended she undergo additional 10 days of interdisciplinary pain rehabilitation program.

Utilization review determination dated 06/14/11 concluded that the request for 80 additional hours (10 sessions) of chronic pain management program for the lumbar spine was not certified as medically necessary. The reviewer noted there was no documentation of changes in physical output parameters. The reviewer indicated that performance on an FCE/PPE could not be a pivotal measure of treatment progress in an interdisciplinary chronic pain rehabilitation program. It was noted there was no documentation of change in pain behavior, verbally and/or non-verbally. There was no change in social functioning external to the program. It was further noted there had been no effort plan or expectation to wean the injured employee from Flexeril which is behaviorally contraindicated in a patient with chronic benign pain. It was noted there has been no effort to coordinate psychological and other care with the injured employee's psychiatrist and records have not been obtained. It was noted there was insufficient evidence that appropriate progress and relevant parameters in the program have been obtained. It was noted that the request for continuation was not submitted for 12 days after the initial program days were completed.

A reconsideration appeal review on 07/05/11 determined the request for additional chronic pain management to be non-certified. It was noted that despite the intensive nature of the program the injured employee had maintained her pain level. In addition she notes reduction in irritability and anxiety. She has maintained functioning and frustration, muscle spasm/tension, depression, sleep disturbance and forgetfulness/poor concentration. She is currently experiencing severe pain during dynamic lifting test. In summary it is noted the injured employee had developed a chronic pain syndrome the treatment of choice is participation in an interdisciplinary pain rehabilitation program. Based on the progress made within 10 days of the program her treating doctor prescribed participation in CPMP as medically necessary. Reviewer noted there was insufficient justification based on medical necessity to certify the request. First it was noted that the injured employee has already received 80 hours of intensive multidisciplinary chronic pain management treatment with minimal success. Requesting provider had little or no further detail on how the second round of the requested treatment will accomplish goals and therefore there is no reason to believe that the second session of treatment will be any more successful than the first session. It was further noted that given that the injured employee had not been properly evaluated by a board certified psychiatrist with a recommendation for second session of 80 hours of intensive chronic pain management treatment was further justification that, from a mental health perspective other lesser levels of treatment have not been properly explored.

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

Upon review of the documentation presented, the request for 80 additional hours of chronic pain management program for the lumbar spine is not indicated as medically necessary. The injured employee sustained an injury to the low back on xx/xx/xx . She completed the initial 10 days of a chronic pain management program. Request for additional 10 days of chronic pain management program was not submitted until 12 days had elapsed from completion of the initial 10 days. The documentation presented reveals minimal response to treatment completed to date. There was no documentation that would indicate that continuation of

treatment would be any more successful than initial treatment. There is no documentation that pain medication usage has been appropriately addressed. Per ODG guidelines, treatment is not suggested for longer than two weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. However it is also not suggested that continued course of treatment be interrupted solely to document these gains if there are preliminary indications that they are being made on a concurrent basis. The documentation as presented does not meet ODG criteria and medical necessity is not established.

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

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)