

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/06/2011

**IRO CASE #:**

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

Chronic Pain Management Program 5x wk x 2 wks, 97799

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

MD, Board Certified Physical Medicine & Rehabilitation  
Board Certified 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**

Official Disability Guidelines  
Utilization review determinations dated 04/25/11, 05/06/11  
Request for medical dispute resolution dated 05/23/11  
Progress summary dated 04/18/11  
Progress notes dated 04/18/11, 04/15/11, 04/05/11, 04/04/11, 03/29/11, 03/25/11, 03/23/11, 03/22/11, 03/21/11, 08/20/10  
Office visit note dated 03/25/11  
Patient reevaluation dated 02/07/11, 01/13/11, 01/10/11, 12/13/10, 11/15/10, 06/21/10  
Initial interview dated 07/06/10  
Designated doctor evaluation dated 01/19/11  
Request for services dated 11/08/10  
Physical performance evaluation dated 11/01/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was moving file boxes and felt a pain in the left side of his groin area. Treatment to date is noted to include diagnostic testing, physical therapy, TENS unit, pain injections, two hernia surgeries, aquatic therapy, individual psychotherapy and medication management. PPE dated 11/01/10 indicates that the patient's required PDL is medium and current PDL is light. Evaluation dated 11/08/10 indicates that BDI is 23 and BAI is 11. Designated doctor evaluation dated 01/19/11 indicates that diagnosis is left inguinal hernia, repaired x 2 with persistent groin and scrotal pain secondary to nerve entrapment; and lumbar strain aggravating degenerative disc disease and degenerative joint disease, multilevel. Progress summary dated 04/18/11 indicates that the patient has completed 9 of 10 authorized chronic pain management program sessions. The patient has reportedly reduced his medication

intake to an as needed basis. BDI is 18 and BAI is 8.

Initial request for chronic pain management program 5 x wk x 2 wks was non-certified on 04/25/11 noting (incorrectly) that the claimant has completed 20 sessions of CPMP. The patient's date of injury is already more than 24 months from the date of the request. A longer duration than 20 days would require individualized care plans for why improvement cannot be achieved as an outpatient. The denial was upheld on appeal dated 05/06/11 noting that the submitted documentation does not provide objective functional gains.

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

The patient has completed 10 sessions of chronic pain management program to date. The submitted progress summary notes state that the patient's BDI has decreased to 18 and BAI to 8. The patient has decreased medications to an as needed basis. Treatment in a CPMP is not suggested for longer than 2 weeks without evidence of compliance AND significant demonstrated efficacy as documented by subjective and objective gains. There is no documentation of objective, functional gains to support additional sessions of the program. There is no updated physical performance evaluation provided. Based upon the current clinical data, the request does not conform to the Official Disability Guidelines for 10 additional sessions of CPMP. The reviewer finds that Chronic Pain Management Program 5x wk x 2 wks, 97799 is not medically necessary.

**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)