

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/07/2011

**IRO CASE #:**

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

Chronic pain management x 80 hours

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

M.D., Board Certified Orthopedic Surgeon

**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

Work Capacity evaluation 01/21/11

Behavioral evaluation report 01/21/11

Progress Summary 03/16/11

pre auth determination 04/26/11, 05/06/11

Request for treatment extension 04/18/11

Dr. office note 04/27/11, 05/20/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who sustained a work related injury to his right shoulder on xx/xx/xx as a result of a slip and fall. The claimant complained of right shoulder pain. The claimant underwent 80 hours of a chronic pain management program. The claimant showed good progress, actively participated in the program and benefitted from treatment. He became independent in self-care with modifications due to his right shoulder pain, expressed interest in returning to work, reported a lower level of pain and voiced considerable interest in managing his pain without the dependency of medication. An extra ten sessions of a chronic pain management program was recommended. This was noncertified by a peer review dated 04/26/11 as desired goals in a comprehensive pain management program should be obtained after 20 sessions of treatment which had already been provided. The medical necessity for the additional 10 sessions was not established. In his appeal letter dated 04/27/22, Dr. noted that the claimant needed additional time to extinguish his regular use of medication and dependence on the healthcare team and the claimant had not completed relapse prevention training. The request was again noncertified in a peer review of 05/06/11 as continuation of the program was not validated by the records. Dr. appealed in the decision and in his letter dated 05/20/11 he again noted the claimant needed additional time to extinguish his regular use of medication and dependence on the healthcare team.

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

This request is for chronic pain management, 80 hours. The diagnosis is that of chronic pain syndrome. Records indicate the claimant has already undergone 20 sessions of chronic pain management and that he did show improvement. Based on the information provided, however, there is no justification for continuation of the program beyond 20 sessions. There is nothing to substantiate the additional hours. While the appeal stated that there was a requirement to extinguish the patient's regular use of medication and dependence on the health care chain, this should have already been performed in the 20 sessions.

Additional sessions are not indicated based on Official Disability Guidelines. The reviewer finds there is not a medical necessity for Chronic pain management x 80 hours. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

**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)