

SENT VIA EMAIL OR FAX ON  
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## Applied Assessments LLC

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/22/2011

**IRO CASE #:**

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

Chronic Pain Management (10) sessions, 8 hours per day for a total of (80)hours

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

Board Certified Anesthesiologist/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. Cover sheet and working documents
2. Adverse determination letter dated 01/20/11, 01/31/11
3. Precertification request dated 01/15/11
4. Work hardening program notes dated 01/10/11
5. Psychological evaluation dated 11/29/10
6. Physical performance evaluation dated 01/12/11
7. Functional capacity evaluation dated 12/20/10
8. Appeal letter dated 01/23/11
9. Pain management consultation dated 09/07/10
10. Follow up note dated 09/30/10, 11/30/10, 12/28/10, 12/07/10
11. Electrodiagnostic visit dated 10/28/10
12. Medication contract dated 12/13/10
13. MRI lumbar spine dated 06/30/10
14. Designated doctor evaluation dated 11/04/10

## **PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was lifting heavy trays and noted low back pain. The patient underwent MRI of the lumbar spine on 06/30/10. Pain management consultation dated 09/07/10 indicates that treatment to date includes 2 sessions of physical therapy and medications with some relief. Electrodiagnostic study dated 10/28/10 revealed electrophysiological evidence of an acute right L5-S1 radiculopathy.

Designated doctor evaluation dated 11/04/10 indicates that the patient has not reached MMI, and her condition would substantially benefit from further evaluation and management. Psychological evaluation dated 11/29/10 indicates that the patient reports increased pain since physical therapy sessions. Medications include Ultram, Ibuprofen and Flector patch. BDI is 33 and BAI is 30. Diagnoses are chronic pain disorder associated with both psychological features and general medical condition; depressive disorder NOS; and anxiety disorder NOS.

Follow up note dated 12/07/10 indicates that the patient is to be scheduled for lumbar epidural steroid injection and will participate in a work hardening program. Functional capacity evaluation dated 12/20/10 indicates that medications include Darvocet, Ibuprofen, Medrol DosePak and Flector patches. The patient has completed 10 sessions of work hardening, per the report. Current PDL is light. Follow up note dated 12/28/10 indicates that the patient has completed 11 of 20 work hardening sessions and is functioning at medium PDL which is her work requirement; however, she continues with severe radicular symptomatology. The patient is scheduled for LESI on 01/07/11.

Work hardening progress notes dated 01/10/11 indicate current PDL is medium. PPE dated 01/12/11 indicates that the patient's current PDL is light.

Initial request for chronic pain management program was non-certified on 01/20/11 noting that the submitted records indicate that the claimant was making steady improvements in functional tasks and in psychological parameter, therefore ODG Pain chapter criteria #2 is not met. The denial was upheld on appeal dated 01/31/11 noting that the patient is not on narcotic medication for management of pain symptoms, and the lack of positive response to previous treatment in the form of 4-week work hardening program would be considered a poor predictor of benefit from the requested program.

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

Based on the clinical information provided, the request for chronic pain management (10) sessions, 8 hours per day for a total of 80 hours is not recommended as medically necessary. The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. The submitted records indicate throughout that the patient presents with severe radicular symptomatology and the patient was scheduled for lumbar epidural steroid injection; however, there is no indication that this injection was ever performed. The patient has been diagnosed with depressive disorder and anxiety disorder; however, there is no indication that the patient has undergone a course of individual psychotherapy or been placed on psychotropic medications. The patient recently completed a work hardening program and progress notes indicate that the patient reached her required PDL of medium; however, PPE dated 01/12/11 indicates that the patient's current PDL is light which indicates that the patient did not improve during the program. The Official Disability Guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program, and note that a chronic pain program should not be considered a "stepping stone" after less intensive programs. Given the current clinical data, the requested chronic pain management program is not indicated as medically necessary, and the two previous denials are 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)