

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Rd Irving, TX
75038
972.906.0603 972.255.9712
(fax)

Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 2, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed chronic pain management program (97799 CP) 5 X week
X 2 weeks

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.2	97799	cp	Prosp	10					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with the non-certification of the request listed above. The reason for the non-certification is that based on the functional capacity evaluation,

there was an ability to meet the job requirements and there is no clear clinical need for a multi-disciplinary protocol. There was no recent physical examination and it was not clear if lower levels of care had been completed.

Reconsideration was completed and the requirements for endorsement of this type of protocol, as per the Official Disability Guidelines, were not met. A second non-certification was issued.

Plain films of the lumbar spine obtained on xx/xx/xx, were noted to be within normal limits. The cervical spine films noted degenerative changes only. The skull series was also noted as normal. The CT of the head did not identify any pathology. An MRI of the lumbar spine noted multiple level degenerative changes, ligamentum flavum hypertrophy and no acute pathology.

The physical therapy notes indicate ongoing low back pain, with no improvement reported by the injured employee. There was a delay in completing the physical therapy secondary to "car trouble".

An orthopedic surgical assessment was obtained. Dr. did not identify a surgical lesion and felt this to be a myofascial lesion; conservative care was recommended. Discontinuance of the muscle relaxants and narcotics was suggested.

Another consultation was obtained that suggested electrodiagnostic testing.

Ph.D. suggested that the non-certification of the CPMP be overturned and employed the IRO process. Individual psychotherapy was completed. The focus was outside stressors causing sleep and anxiety issues. After six sessions, there is no evidence that any of this intervention achieved any of the stated goals.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines, such a program is recommended when there is access to programs with proven successful outcomes. There is no data presented outlining that this protocol has any measurable success. While noting that there is no reported subjective improvement, there is no competent, objective or independently confirmable medical evidence of any pathology that would be causative of the pain complaints. The plain and enhanced imaging studies only noted ordinary disease of life degenerative changes. The individual psychotherapy did not result in any positive outcomes. The medication use increased, and went well beyond the parameters noted in the formulary use guidelines reported in the Official Disability Guidelines. There has to be a reasonable chance of success with this protocol. When considering the reported mechanism of injury, the lack of any pathology, the findings of the orthopedic surgeon and the lack of response to individual psychotherapy, there simply is not a reasonable expectation that any improvement would occur as a result of this program. There is no basis to overturn the non-certification for this request.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)