

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: SEPTEMBER 28, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed 10 sessions of chronic pain management program (97799)

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
723.4	97799	cp	prosp	10				C0520521	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a copy of an August 18, 2011 request for preauthorization for chronic pain management. D.C., filed the request. The same day a collaborative report for reconsideration of a chronic pain management program is also filed. It was noted that there were high psychological scores, no visible return to work plan and a clinical

indication that the injured worker did not meet the criterion for a chronic pain program. The assertions of the preauthorization reviewer were refuted.

The reported mechanism of injury was a slip and fall backward, resulting in a head, neck and low back injury. Imaging studies did not reveal any acute pathology. There was diffuse lumbar and cervical osteophytosis. Electrodiagnostic studies did not objectify any evidence of radiculopathy. The reported neurologic examination demonstrated a decrease in sensation in the right hand and bilateral legs without a direct dermatomal pattern. It was noted in the clinical impressions section that there was some inflation on the part of the patient relative to the test scores.

A behavioral health evaluation with the purpose of requesting 10 sessions of multidisciplinary chronic pain program was completed. It is noted that the claimant has applied for Medicare and Medicaid support. A pain disorder was diagnosed and the requested chronic pain program was endorsed.

A chiropractic driven functional capacity evaluation is also reviewed demonstrating a complete lack of effort on the part of the injured employee.

There are a number of prior progress notes from the requesting provider dating back to November 2010. An orthopedic consultation was obtained and apparently focused on the cervical spine injury alone.

The pain management consultation started in June. The medical records from the initial injury emergency room visit are reviewed and again the degenerative changes are the only findings noted on imaging studies. The cervical spine and upper extremity electrodiagnostic studies were all wholly normal.

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/GUIDLINES 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 indicated when the outcomes of a program have been objectified. No such objectification is noted. The injured worker has applied for Medicare and Medicaid assistance and as tempered by the fact that there were minimal physical examination findings, and changes on the imaging studies indicating a rather minimal injury. The complaints far exceed the objective parameters. The functional capacity evaluation again endorsed a lack of objective clinical reason for the chronic

pain presentation. Please refer to the straight leg raise of 4° on the right and left in an individual that has no evidence of disc herniation or nerve root compromise. Additionally, the range of motion of the lumbar spine is also similarly markedly reduced in what appears to be a voluntary effort to inflate the severity of the pathology.

When noting the specific criterion for a multidisciplinary chronic pain management program such a program may be considered medically necessary in the following circumstances, and please note there are 15 circumstances to be met, there was no consideration or evaluation from an addiction medicine specialist (5), when noting that the injured worker has applied for Medicare and Medicaid support services, there is no clear documentation that there is any motivation to change (7), there are negative predictors of success as there is no cooperation and inflation of the psychiatric data as reported by the evaluator (8) all speak against the endorsement of such a program.

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)