Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Oct/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management 80 hours 5 X wk X 2 wks

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Utilization review findings 08/25/11
Utilization review findings 09/14/11
Insurance Company's response regarding disputed services 09/23/11
Designated doctor evaluation 12/07/05
Chiropractic notes
Report of operation left L5-S1 partial hemilaminotomy and foraminotomy 06/12/06
Office notes Dr.
Mental health evaluation 07/25/11
Chronic pain management program treatment plan / progress report
Impairment evaluation 07/01/11
Diagnostic / imaging studies lumbar spine including CT myelogram, Flexion / extension radiographs, MRI lumbar spine, and EMG/NCV
Mental health and behavioral assessment 08/16/10
Psychotherapy progress notes 10/05/10-12/13/10
Consult report Dr. 08/26/10
Physical therapy daily progress notes
Consult / office notes Dr. 07/26/05-10/20/05
History and physical examination Dr. 08/10/05
Progress notes Dr. 11/01/05

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xxxx. Records indicate he injured his low back when he had to repair conveyer and hang over the edge and twist and work underneath somewhat hanging by his legs. The claimant is status post left sided flavotomy, partial hemilaminotomy and foraminotomy at left L5-S1 performed 06/12/06. He continued to complain of constant low back pain left greater than right with radiation into left calf and foot. Records indicate the claimant had multiple epidural steroid injections, physical therapy, oral medications, and home exercise program. He experienced some temporary relief following epidural steroid injections, but minimal at best and only temporary. Records indicate the claimant also participated in course of individual psychotherapy from 10/05/10-12/03/10. Mental health evaluation dated 07/25/11 indicated the claimant is an appropriate candidate and would benefit from treatment in an interdisciplinary chronic pain management program.

A utilization review dated 08/25/11 determined the request for chronic pain management program 80 hours, 5 times a week x 2 weeks to be non-certified as medically necessary. The reviewer noted that peer to peer discussion was completed with Dr. This is request for enrollment of chronic pain management program. It was noted psychological and functional capacity evaluation was submitted for review. It was also noted that behavioral goals for requested program is documented; however, the short term and long term physical rehabilitation goals were not provided. Records also did not provide objective documentation of failure of conservative treatment such as optimized pharmacotherapy and recent or ongoing active rehabilitation. Furthermore, there is no documentation of recent monitoring of the claimant's prolonged opioid intake. The negative predictors for success of program are not identified and addressed in submitted records. Hence medical necessity was not established at this point.

A utilization review performed 09/14/11 recommended non-certification of appeal request for chronic pain management program 80 hours, 5 times a week x 2 weeks. The reviewer again noted peer to peer discussion with Dr. The reviewer noted receiving additional documentation including functional capacity evaluation and letter stating physical therapy notes were not received. The claimant is a male who sustained an injury on xx/xxx/xxxxx and presented with persistent low back pain. Official Disability Guidelines recommend chronic pain management for patients when specific criteria have been met. There was lack of documentation submitted for review to detail the claimant is willing to change medication regimen. The documentation submitted for review does provide objective psychological testing scores but no physical therapy notes have been submitted for review. The claimant was retired prior to returning to work and sustained an injury after working for eight months and has not returned to work since date of injury and outcomes for necessity of the program have not been clearly identified since he has been out of work greater than 24 months. These negative predictors of success have not been identified. Therefore the request is not warranted per evidence based guidelines. As such the clinical documentation submitted for review does not support certification of the request at this time.

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

Based on the clinical data provided, the request for chronic pain management 80 hours five times a week times two weeks is not indicated as medically necessary. The claimant sustained an injury to the low back on xx/xx/xxxx and subsequently underwent surgery on 06/12/06 with left sided flavotomy, partial hemilaminotomy and foraminotomy at the L5-S1 level. He continued to complain of low back pain radiating to the lower extremities. He underwent extensive treatment including epidural steroid injections with only mild and temporary relief. Treatment also includes medications, physical therapy and home exercise program. Records reflect that the claimant completed five visits of individual psychotherapy. He was recommended for chronic pain management program. However it was noted that the claimant has been out of work for over 24 months. Per Official Disability Guidelines, there is conflicting evidence that chronic pain programs provide return to work beyond this period. 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)