

Core 400 LLC

An Independent Review Organization
7000 N Mopac Expressway, Suite 200
Austin, TX 78731
Phone: (512) 772-2865
Fax: (530) 687-8368
Email: manager@core400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/23/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management program x 80 hrs

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

M.D., Board Certified Anesthesiology/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

Official Disability Guidelines

Utilization review determination dated 02/14/12, 03/05/12

Request for 80 hours of a chronic pain management program dated 02/09/12

Functional capacity evaluation dated 01/19/12-01/26/12

History and physical dated 12/01/11

Chronic pain management plan and goals of treatment dated 02/08/12

Psychological testing results dated 08/19/11

Initial behavioral medicine consultation dated 12/14/09

Evaluation for chronic pain management program dated 02/08/12

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. He was working when a 15-20 foot column weighing approximately 1000 pounds fell on his left shoulder. Behavioral medicine consultation dated 12/14/09 notes he has had diagnostic testing, physical therapy and medication management. Diagnosis is adjustment disorder with mixed anxiety and depressed mood, secondary to the work injury. Psychological testing results dated 08/19/11 indicate that the patient has undergone a lumbar epidural steroid injection. The patient is reportedly considered as a surgical candidate, but he does not desire to be operated on. MMPI-2-RF profile is valid. Diagnosis is pain disorder associated with both psychological factors and a general medical condition; major depressive disorder, mild. History and physical dated 12/01/11 indicates that medication is Norco. Functional capacity evaluation performed in January 2012 indicates that current PDL is light and required PDL is heavy. Evaluation dated 02/08/12 states that BDI is 18 and BAI is 12. The patient has reportedly undergone individual psychotherapy and biofeedback.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The patient has reportedly undergone 24 sessions of individual psychotherapy and 12 sessions of biofeedback. The most recent psychological assessment is from August 2011, prior to completion of psychological treatment. There is no updated psychological evaluation submitted for review to establish the patient's current psychological status. The patient presents with significant psychological issues given the extensive nature of psychological treatment provided; however, the patient is not currently taking any psychotropic medications. The ODG do not generally support chronic pain management programs for patients who have been continuously disabled for greater than 24 months as there is conflicting evidence that chronic pain programs provide return to work beyond this period. This patient's date of injury is over 2 ½ years old. The reviewer finds the requested Chronic pain management program x 80 hrs is not medically necessary.

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)