

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: JULY 25, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Chronic Pain Management program (97799 CP), 80 hours

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
843.90	97799	CP	Prosp	80					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-15 pages

Respondent records- a total of 29 pages of records received to include but not limited to: TDI letter 7.5.12; letter 6.12.12; Clinic records 5.3.12-7.6.12; Behavioral Evaluation report 5.31.12; Hospital notes 4.8.12-4.9.12

Requestor records- a total of 32 pages of records received to include but not limited to: TDI letter 7.5.12; letter 6.12.12, 7.2.12; Clinic records 5.3.12-6.25.12; Behavioral Evaluation report 5.31.12

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with the copy of the emergency room note indicating a left shoulder injury. The impression was atypical chest pain. The electrocardiogram noted a normal sinus rhythm. Plain films of the chest noted no acute process,

no focal consolidation, no plural effusion or pneumothorax. There was a normal cardiac silhouette reported.

On May 3, 2012, a work conditioning discharge report is noted. It was reported that after 16 hours of this protocol there was an exacerbation of the pain complaints. It was reported that the employee was "focused on his pain".

A behavioral evaluation report was completed on May 31, 2012. This evaluation suggested 20 sessions of a chronic pain program. Additionally, individual psychotherapy was initiated.

The initial review noncertified the request due to inappropriate medications being employed; it was uncertain as to what medications were being employed. This was a third request for this program as opposed to seeking higher levels of appeals. The work conditioning program was noted as it was felt that some of the diagnostic findings were "overstated". This precipitated a request for reconsideration.

The reconsideration was for a MODIFIED chronic pain management program. It was felt that only the services that are included within a chronic pain management program would achieve maximum medical improvement.

The reconsideration was also not certified. The non-certification of the reconsideration was based in part on the comorbidity of chest pain, the comorbidity of no functional capacity evaluation after a cerebral vascular accident, and there was no significant rationale to support endorsement of such a program.

In the cover letter referencing the referral to this IRO it was noted that there was a right hip and abdomen injury. It would appear that there were functional deficits and a depressive reaction to this injury. It is reported that the patient does not have adequate pain management and stress management skills. Significant vocational readjustment is also a requirement.

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:

The first point to make is that this referral is for a modified chronic pain management program. We also should note that a work conditioning program failed. Individual psychotherapy is not noted to have been successful. The exact parameters of this modified program are not established in any other referral documentation.

The second point to make is that there are several comorbidities (atypical chest pain, cerebral vascular accident) that would compromise the utility of such a program.

The third point to note is that subsequent to the work conditioning program it was reported that the patient "achieved the upper limits of his functional abilities" and he has plateaued. There are complaints of right hip and inguinal pain without any objectification of significant pathology that would be causative of such a clinical situation. I would also point out that with the work conditioning discharge report it was noted that the "functional disability is considered to be out of proportion to the severity of the diagnosed injury" for this patient. Therefore, there is no reasonable expectation of success of such a modified chronic pain program endeavor.

As noted in the Division mandated Official Disability Guidelines, a chronic pain program is recommended when there is access to production programs with proven successful outcomes.

No such applicable data is presented to be reviewed, e.g. success and outcome data. When noting the general criteria established in the Official Disability Guidelines, there is a lack of a several multidisciplinary evaluation in terms of the actual injury sustained, the diagnosis associated with the injury, and any pathology that was the sequelae of the compensable event. (Criteria #3)

Inasmuch as this has been referred to as a modified chronic pain program, a specific treatment plan for treatment to identify problems and expected outcomes was not presented. (Criteria #6)

Given the failure of the work conditioning program, the response to the individual psychotherapy, and the lack of specific data to suggest that there is any motivation to change on the part of this gentleman, who was noted to be homeless and divorced, and walked away from his position; the standards noted in criteria #7 are not met.

Therefore, given the lack of the above noted criterion, the failures of prior interventions without any objectification or identification of a desire to improve or change, there is simply no indication of any reasonable expectation of success of this program. Therefore, this request cannot be endorsed as medically necessary.

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