

# Prime 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Nov/28/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

10 Day Chronic Pain Management (97799)

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

M.D., Board Certified Pain 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that the requested 10 Day Chronic Pain Management (97799) is not indicated as medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 10/12/12, 11/01/12

Mental health and behavior assessment dated 09/28/12

Treatment plan/progress report dated 09/27/12

Functional capacity evaluation dated 09/20/12, 05/08/08

Office visit note dated 09/17/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male. The patient was carrying a heavy piece of equipment and he was holding a door open with his left foot. His foot slipped on the icy ground and he dropped the heavy piece of equipment and then fell on top of it. Functional capacity evaluation indicates that required PDL is medium/heavy and current PDL is medium. Mental health and behavior assessment dated 09/28/12 indicates that treatment to date includes MRI, epidural steroid injections, facet injections, physical therapy, TENS unit and medication management. Current medications are Depakote, Gabapentin, Tramadol, Clonazepam, and Ambien. BDI is 26 and BAI is 36. Diagnoses are adjustment disorder with mixed anxiety and depressed mood; and pain disorder associated with both psychological factors and a general medical condition.

Initial request for 10-day chronic pain management was non-certified on 10/12/12 noting that no clinical documentation was submitted from the patient's primary physician regarding the patient's compliance or noncompliance with treatment. The guidelines note that little research exists regarding the success of return to work with functional restoration program in long-term disabled patients of over 24 months. The documentation submitted for review,

lacked evidence of the patient's commitment to change in terms of his medication regimen and documentation that the patient was aware that successful treatment may change compensation and/or other secondary gains. In addition, documentation did not include evidence of previous failed conservative therapies. Appeal/reconsideration dated 10/26/12 indicates that the patient has expressed interest in these services indicating he would be compliant with the program requirements and treatment interventions. He has been compliant with all previous treatments. The denial was upheld on appeal dated 11/01/12 noting that there is no documentation of the patient's response to these various components of his conservative care to date.

There was no documentation of the patient's physical therapy, the patient's response to epidural steroid injections, nor the use of his personal TENS unit. The documentation submitted for review did not include a comprehensive physical examination of the patient's lumbar spine. The documentation submitted for review noted the patient to have not made a return to work since his date of injury. The clinical notes did not indicate what the patient's plan was for return to work efforts. Guidelines also indicate in a progress plan for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain management programs provide return to work beyond this period.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no indication that the patient has undergone a course of individual psychotherapy to address reported symptoms of anxiety and depression. The patient's date of injury is over five years old. The Official Disability Guidelines 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 these programs provide return to work beyond this period. It is the opinion of the reviewer that the requested 10 Day Chronic Pain Management (97799) is not indicated as 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)