



Notice of Independent Review Decision

DATE OF REVIEW: 12/29/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program 80 Hours 97799

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

Board Certified in Physical Medicine & Rehabilitation

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 or not medical necessity exists for each of the health care services in dispute.

Chronic Pain Management Program 80 Hours 97799 – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Initial Medical Report, Spine & Rehabilitation Centers, 03/03/11

- Physical Therapy, Spine & Rehabilitation Centers, 03/10/11, 03/15/11, 03/17/11, 03/24/11, 05/18/11, 05/25/11, 05/31/11, 06/01/11, 06/02/11
- Initial Consultation Notes, M.D., 04/15/11
- Manual Muscle Testing and Range of Motion, Diagnostics, 04/15/11
- Electrodiagnostic Studies, Neurological Association, 04/21/11
- Neurological Consultation, M.D., 04/21/11
- Follow Up Evaluation, Dr. 05/25/11
- Brain MRI, M.D., 05/06/11
- Follow Up Consultation Report, D.O., 06/02/11
- Behavioral Evaluation Report, M.A., L.P.C., 10/20/11
- Work Capacity Evaluation, Functional Testing, 10/20/11
- Pre-Authorization Request, Pain & Recovery Clinic, 10/27/11
- Denial Letters, 11/02/11, 11/17/11
- Request for Reconsideration, Pain & Recovery Clinic, 11/04/11
- Independent Medical Evaluation (IME), M.D., 11/10/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The records available for review document that on the date of injury, the patient sustained a slip and fall incident in the workplace. It was documented that she was with symptoms of low back pain, as well as left lower extremity pain, and headaches after the event occurred.

The patient was evaluated by Dr. on 04/15/11. It was documented that a lumbar MRI had been accomplished on 03/21/11. The study revealed evidence for disc desiccation of a minimal nature at the L4-L5 level. It was also documented that a CT scan of the head had been recommended by a neurologist who had evaluated the patient. It was documented that her past history was normal for the fact that she had recently been diagnosed with a deep venous thrombosis in the left lower extremity which required hospitalization for approximately one week. After Dr. evaluated the patient on that date, she was provided a prescription for Norco and Soma.

An electrodiagnostic assessment of the lower extremities was obtained on 04/21/11. The study was described as "normal." There were no findings worrisome for an active lumbar radiculopathy.

The patient was evaluated by Dr. on 04/21/11. The physician recommended that the patient be provided Topamax for assistance with respect to symptoms of headaches.

On 05/06/11, an MRI of the brain was accomplished. The study was essentially unremarkable, with the exception of the fact that there was evidence for mild mucous membrane thickening within the ethmoid air cells.

The patient was evaluated by Dr. on 05/25/11. It was documented that an EEG had been accomplished, which was unremarkable. It was documented that she was with symptoms of emotional overlay. It was recommended that she be maintained on Topamax, but the dose was increased to a regimen of 100 mg twice a day.

On 06/02/11, Dr. evaluated the patient. It was recommended that consideration be given for treatment in the form of a comprehensive pain management program.

The patient was evaluated by Dr. on 09/10/11. It was documented that she had received access to treatment in the form of physical therapy services. It was also documented that a Designated Doctor Evaluation (DDE) was conducted on 06/14/11, which indicated that the patient was at a level of Maximum Medical Improvement (MMI).

A behavioral evaluation report was obtained, dated 10/20/11. It was noted that the patient had been an employee at her place of employment for approximately three months prior to sustaining the documented injury in the work place. It was noted that she was employed as a.

A Functional Capacity Evaluation (FCE) was accomplished on 10/20/11. It was documented that the patient was capable of sedentary/light category work activities.

A pre-authorization request was submitted by the pain and recovery clinic dated 10/27/11. It was recommended that the patient receive access to treatment in the form of a comprehensive pain management program.

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

Based upon the medical documentation presently available for review, there would not appear to be any medical necessity for treatment in the form of a comprehensive pain management program. The date of injury is approaching one year in age. The records available for review indicate that diagnostic studies obtained after the date of injury did not reveal a significant acute pathological process with respect to the affected physical structures of the body. There would appear to be a lack of objective findings on objective diagnostic tests accomplished after the date of injury to support the subjective complaints. Additionally, the submitted medical documentation does not provide sufficient data to indicate that lesser levels of care have been attempted. When an FCE was accomplished, it appeared that the patient was essentially at a level of pre-injury work activities. The records available for review do not provide documentation to indicate if there has been an attempt to return the patient to modified work activities. Consequently, per the criteria set forth by the Official Disability Guidelines, medical necessity for an extensive program in the form of a comprehensive pain management program as it relates to the work injury of xx/xx/xx is not presently established.

**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
- 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)
- AMA GUIDES 5TH EDITION