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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 11/22/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten sessions of Chronic Pain Management Program for symptoms of Anxiety and Depression related to Right Shoulder, Cervical Spine and Lumbar Spine injury, 5 times a week for 2 weeks, as Outpatient.
CPT: 97799

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

Physician Board Certified Pain Management & Anesthesiology.

REVIEW OUTCOME

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

Upheld	(Agree)
Overtured	(Disagree) <u>X</u>
Partially Overtured	(Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Letters requesting CPMP, (2) Balance, / 7/29/13; 8/06/13

Adverse Determination Letter (w/ODG): Peer Review, 9/12/13

Reconsideration/Appeal Letters (w/ODG): Peer Review, 10/11/13

Appeal Letter: Balance,

Clinical Notes, include: Balance: Initial Mental Health Evaluation 7/23/13; 30 Day Follow-Up w/individual treatment plan, Physical Examination, 11/01/13; Individual Counseling Notes (6): 8/29/13-8/20/13; Clinic Note: Brief Clinical Summary, Current Status, Medications, Recommendations, 11/01/13, 7/26/13; MRI's: C-Spine, L-Spine, Rt Shoulder: MRI & Diagnostic, 6/11/13, 6/11/13, 6/26/13; MRI's (4): 2009

Functional Capacity Evaluation (2): 7/31/13, 3/20/13

Operative Reports (2): 11/26/13, 3/03/10; Operative Report (1): 1/28/19;

ODG (Official Diagnostic Guide)

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male who sustained a work related injury in xx/xxxx which resulted in back, neck and shoulder pain. After failure of conservative therapy, including injection therapy, various surgeries were performed: two back surgeries in 2008 and 2009; shoulder surgery in 2009, and neck surgery in 2008. There is persistent, severe pain. A functional capacity evaluation indicated the ability to perform at a light physical level which does not meet claimants requirements or the job and employer requirements. A heavy physical demand level is required. In his appeal letter of 7/29/13, addresses ODG criteria for a Chronic Pain Management Program, but there is no evidence in the records of substance abuse. There are current medications including Narco, Robaxin, and Ambien.

A previous reviewer has stated that “the records do not reflect the claimant has a motivation to change” (memo dated 9/12/13). However, in a memo dated 7/29/13, it is stated that “the patient is very eager to return to work, and wishes to process as soon as possible”. “There are no medical contradictions to the Chronic Pain Management Program, the goals are outlined, and initial request is for 10 sessions”.

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

Decision:

I disagree with the benefit company's decision to deny the requested service.

Rationale:

A previous reviewer has stated that since the disability is longer than 24 months, a Chronic Pain Management Program is contraindicated. ODG states that the likelihood of success is equivocal, but does not prohibit a pain management program. Therefore, the criteria for the multidisciplinary program are met. It is reasonable to authorize the requested pain management program.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & 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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)