

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Apr/02/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** chronic pain management program, 80 hours

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D. O. 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 request for chronic pain management program, 80 hours is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization review determination dated 02/22/13, 03/01/13  
Preauthorization request dated 02/18/13  
Behavioral evaluation report dated 02/01/13  
Functional capacity evaluation dated 01/17/13  
Request for reconsideration dated 02/25/13  
Note dated 03/13/13  
Follow up note dated 01/24/13, 11/07/12, 10/10/12, 04/05/12, 03/07/12, 01/16/13, 01/14/13, 01/10/13, 01/08/13, 01/04/13, 01/02/13, 12/28/12, 12/20/12, 12/19/12, 12/17/12, 12/14/12, 12/12/12, 12/10/12, 12/07/12, 12/05/12, 12/03/12, 11/30/12, 11/29/12, 11/27/12  
MRI right hip dated 02/17/11  
MRI lumbar spine dated 02/17/11  
Radiographic report dated 01/19/11  
Daily patient therapy note dated 10/19/11, 10/17/11, 10/13/11, 10/12/11, 10/10/11, 10/06/11, 10/03/11, 09/29/11, 09/27/11, 09/21/11  
Occupational description undated  
Operative report dated 04/22/11, 05/27/11

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xxxxxx. On this date the patient was moving large boxes and a cooler when he felt a pain radiating around his groin area. Treatment to date includes physical therapy, epidural steroid injection on 04/22/11, lumbar facet joint injections on 05/27/11, right L4-5 laminectomy on 09/27/12 and medication management. Functional capacity evaluation dated 01/17/13 indicates that current PDL is light and required PDL is heavy. Behavioral evaluation report dated 02/01/13 indicates that PAIRS score is 78. BDI is 27 and BAI is 22. Diagnoses are

major depression moderate; and pain disorder associated with both psychological factors and a general medical condition. Current medications are listed as Ultram, Flexeril, Lyrica and Cymbalta.

Initial request was non-certified on 02/22/13 noting that the patient has high psychosocial stressors of anxiety and depression which have not been addressed. The claimant has been stated to have received an unspecified surgery to the lumbar spine but still has ongoing complaints of pain. Records do not reflect whether postoperative treatment has been exhausted including physical therapy or further diagnostic studies for ongoing pain. There is a lack of detail to the clinical history of the injury including all treatment and current medications. The multidisciplinary screening lacks a significant detail in regard to addressing the claimant's anxiety and depression, current use of medication and past exhausted treatments and a full diagnosis has not been disclosed. Request for reconsideration dated 02/25/13 indicates that he does not have the pain and stress management skills necessary to adequately function in the presence of constant pain. The denial was upheld on appeal dated 03/01/13 noting that there are no medical records other than notes submitted from the evaluation by the pain program. There is none of the treating physician's records. There are no diagnostic studies from the physician. There is no information as to exactly what treatment the claimant had, what surgery the claimant had, what the response was to medication, what medication the claimant was taking, how much physical therapy the claimant had, has the claimant had any psych therapy or have been treated for any of the psychological conditions listed in the evaluation.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries in January 2011 and has undergone treatment including surgical intervention, physical therapy, injection therapy and medication management. However, 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. The patient has been diagnosed with major depressive disorder; however, there is no indication that the patient has undergone a course of individual psychotherapy. The patient has been treated with antidepressant medication; however, the Official Disability Guidelines report that the gold standard of treatment for major depressive disorder is a combination of individual psychotherapy and medication management. As such, it is the opinion of the reviewer that the request for chronic pain management program, 80 hours is not recommended 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)