

# Core 400 LLC

An Independent Review Organization  
7000 N Mopac Expressway, Suite 200  
Austin, TX 78731  
Phone: (512) 772-2865  
Fax: (530) 687-8368  
Email: manager@core400.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Feb/13/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 80 units of chronic pain management sessions

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D. Board Certified Anesthesiology and Pain Management

**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 80 units of chronic pain management sessions is not recommended as medically necessary.

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

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization review determination dated 12/20/12, 01/17/13  
Request for services dated 10/09/12  
Functional capacity evaluation dated 11/20/12  
Request for reconsideration dated 01/10/13  
Office note dated 09/27/12

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. Request for services dated 10/09/12 indicates that the mechanism of injury is described as slipping into a rut from heavy equipment and twisting his body. Treatment to date is listed as x-rays, MRIs, physical therapy, pain injections, and TENS unit. Current medications are listed as hydrocodone, Gabapentin and Zolpidem. BDI is 14 and BAI is 23. FABQ-W is 42 and FABQ-PA is 22. Diagnosis is pain disorder associated with both psychological factors and a general medical condition. Initial functional capacity evaluation dated 11/20/12 indicates that current PDL is sedentary and required PDL is heavy.

Initial request for 80 units of chronic pain management sessions was non-certified on 12/20/12 noting that there is not an adequate and thorough multidisciplinary evaluation to determine the appropriateness of this request. There is not a current physical examination by the physical associated with the CPMP that rules out other conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable

pathology, including imaging studies and invasive injections should be completed prior to considering a patient a candidate for a program. This injury is over xx years old. The request is inconsistent with the requirement that "if a program is planned 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 programs provide return to work beyond this period". The duration of this injury which is a negative predictor of success is not assessed. The denial was upheld on appeal dated 01/17/13 noting that the patient is nearly xx years post injury. ODG states that there is little research as to successive return to work with functional restoration programs in long-term disabled patients, over xx months. Studies have concluded that early intervention is the key to response of the programs and the goal should be modest.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries on xx/xx/xx, approximately xx years ago. The Official Disability Guidelines do not generally support chronic pain management programs for patients who have been continuously disabled for greater than xx months as there is conflicting evidence that these programs provide return to work beyond this period. The submitted records fail to establish when the patient last worked. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient's date of injury is xx./xx/,xx yet the earliest record submitted for review is dated 09/27/12. As such, it is the opinion of the reviewer that the request for 80 units of chronic pain management sessions 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)