

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jun/12/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** chronic pain management program 5 x wk x 2 wks, 80 units

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O. Board Certified Physical Medicine and Rehabilitation and 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 5 x wk x 2 wks, 80 units is not recommended as medically necessary

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization review determination dated 03/27/13, 05/06/13  
Progress note dated 04/28/10, 06/08/10, 08/30/10, 11/11/10, 05/09/11, 11/07/11, 04/04/12, 08/22/12, 10/25/12, 12/03/12, 01/07/13  
Progress note dated 02/21/13, 03/19/13, 03/20/13  
Request for reconsideration dated 04/16/13  
Request for 10 sessions of chronic pain management program dated 03/06/13  
Functional capacity evaluation dated 12/11/12  
Handwritten note dated 10/25/12  
Initial examination dated 12/03/12  
Musculoskeletal evaluation invoice dated 01/07/13  
Range of motion testing dated 01/07/13  
Initial interview dated 10/25/12

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient bent over to pick up a feather and felt pain in her back. Treatment to date includes partial laminectomy and discectomy and L4-5, epidural steroid injection, diagnostic testing, physical therapy, aquatic therapy and medication management. Initial interview dated 10/25/12 indicates that current medications are Losartan, Protonix, Lasix, Lopid, Balsalazide, Neurontin, OcuVite vitamin, acidophilus probiotic, Bayer Aspirin, Omeprazole, Atenolol, Cymbalta, Amrix, and Neurontin. The patient displays a very good work ethic and has already retired. BDI is 6 and BAI is 24. Diagnosis is pain disorder associated with both psychological factors and a general medical condition, acute. Functional capacity evaluation dated 12/11/12 indicates

that current PDL is sedentary. And required PDL is light. The patient subsequently underwent a course of individual psychotherapy. Request for chronic pain management program dated 03/06/13 indicates that BDI remains 6 and BAI has decreased to 11.

Initial request for chronic pain management program 5 x wk x 2 wks was non-certified on 03/27/13 noting that it remains unclear if the patient had continued to use narcotic medications. The patient's low scoring for depression and anxiety coupled with her low pain rating of 2-3/10 does not lend itself to the need for a chronic pain management program of this type. The denial was upheld on appeal dated 05/06/13 noting that the patient's date of injury is over 12 years old.

Current evidence based 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.

**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 and the submitted records indicate that the patient has already retired. The Official Disability Guidelines do not recommend 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. The patient does not present with significant psychological indicators given BDI is 6 and BAI is 11. As such, it is the opinion of the reviewer that the request for chronic pain management program 5 x wk x 2 wks, 80 units 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)