Core 400 LLC

An Independent Review Organization
2407 S. Congress Avenue, Suite E #308
Austin, TX 78704
Phone: (512) 772-2865
Fax: (512) 551-0630
Email: manager@core400.com

November 26, 2018

Description of the service or services in dispute:

XX sessions of chronic pain management program (CPMP).
XX - Other XX Medicine and Rehabilitation Service or Procedures (XXXX)

Description of the qualifications for each physician or other health care provider who reviewed the decision: Board Certified Anesthesiology

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

☐ Overturned (Disagree)
☑ Upheld (Agree)
☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX. XXXX complained of XX XX pain. The diagnoses included XX of unspecified muscle, XX and XX at XX and XX XX level, XX XX, initial encounter (XX.XX); XX of unspecified muscle(s) and tendon(s) at XX XX level, XX XX, initial encounter (XX.XX), and injury, unspecified (XX.XX), and pain disorder with related XX factors.

Per a follow-up to initial XX XX evaluation dated XXXX, XXXX presented for a follow-up. XXXX had completed XX sessions of the chronic pain management program (CPMP) which had helped XXXX significantly to XX XX with XXXX injury. XXXX continued to experience chronic pain to the XX XX and XX XX. XXXX described reduced XX pain level of XX/10 and the XX pain at XX/10. XXXX continued to have difficulty while lifting. XXXX described improved range of motion and flexibility to the XX XX. XXXX stated that XXXX was less XX with a decrease in XXXX XX XX. The XX XX had stopped. XXXX concentration had improved. XXXX continued to struggle with XX. It was recommended that XXXX complete XX additional sessions of the chronic pain management program to address the chronic pain, increase XX skills, and help reinforce XX XX so that XXXX could return to work. On XX XX examination, XXXX affect was XX and XX was XX. XX XX Inventory-XX (XX-XX) score was XXXX, XX XX XX (XX) score was XXXX, and XX XX XX Questionnaire score (XX)

was XXXX, and "XX" score was XXXX. The diagnoses included pain disorder with XX XX XX.

A functional capacity evaluation (FCE) was completed by XXXX. On examination, XXXX exhibited a XX XX range of motion with XX at XX degrees / XX degrees, extension at XX degrees / XX degrees, XX rotation at XX degrees / XX degrees, XX rotation at XX degrees / XX degrees, XX and XX XX flexion at XX degrees / XX degrees each. Range of motion at XXXX XX XX was normal. XX XX range of motion was limited; XX was XX degrees, extension was XX degrees, XX was XX degrees, internal and external rotation was XX degrees. The strength was XX+/5 for the XX XX, XX, and XX XX. There was XX and XX sensation at the XX XX XX XX. Examination of the XX XX revealed an increase in XX XX XX and XX in the XX region. The examination of the XX XX revealed XX in XX XX XX, XX of the XX joint (XX joint), XX (XX) joint, and XX tendon upon palpation. XX XX test provoked pain at the XX XX. XXXX was able to reach the XX with the XX XX. Examination of the XX XX revealed XX XX and XX at the XX aspect of the XX XX. XXXX had unresolved XX XX pain and had XX range of motion, secondary to XXXX work-related injury. This greatly affected XXXX functional capacity and was a hindrance to XXXX overall recovery. XXXX physical demand level was at XX / XX.

An MRI of the XX XX dated XXXX revealed the XX parts of the XX XX were well maintained. The XX tendon and XX tendons were XX and the XX was intact. There was no tear along the XX or XX XX. There was no tear along the XX or XX XX. There was some induration along the XX margin of the XX margin of the XX XX, but there was no fracture and the adjacent XX tendon did not show any abnormality. The XX XX of the XX meniscus showed some XX, but XX XX identified.

An MRI of the XX XX dated XXXX showed the bony parts of the XX XX did not show evidence of fracture or dislocation. The XX (XX) joint showed XX XX XX, which did cause relatively XX XX along the XX XX of the XX XX. No fluid was identified along the XX muscle. The XX joint was adequately maintained. The muscle XX of the XX were adequately maintained. The XX tendon was adequately maintained with no evidence of a XX. The XX XX showed thinning, but no tear was identified. The XX XX showed XX XX XX, but no complete XX was identified.

The treatment to date included medications (XXXX), injections, XX XX, XX, XX therapy, and XX sessions of chronic pain management program (CPMP).

Per a utilization review decision letter dated XXXX, the requested service of XX sessions of chronic pain management program was denied by XXXX. Rationale: "The Officially Disability Guidelines (ODG) recommends continuation of a chronic pain management program beyond an initial XX hours if there is ongoing evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. The documentation provided indicates that the injured worker has had subjective improvement in range of motion, XX, XX, and concentration with the initial XX hours of pain management program. There are ongoing complaints of pain in the XX XX and XX, and difficulty with XX. There is no documented objective functional improvement. There is documented improvement on testing for XX and XX.

Based on the documentation provided, the ODG would not support the continuation of a chronic pain management program as there is no documented objective improvement in functional capacity. As such, the request is recommended for noncertification."

Per a utilization review reconsideration letter dated XXXX, the prior denial was upheld by XXXX. Rationale: "As per the medical record review XXXX, it is stated the patient has reached XX medical improvement (XX). Per this review, the claimant has had reasonable treatment to date for the work injuries, and no additional treatments are indicated as such. There is no rationale for XX sessions of chronic pain management program. Hence, this request is not medically necessary."

An appeal letter was written by XXXX. XXXX documented that the requested service of chronic management program (CPMP) was denied. As per the insurance company, XXXX was already at XX medical improvement (XX). Per the Designated Doctor Examination dated XXXX, XXXX was not at XX. XXXX had attended XX sessions of CPMP with good progress. This delay on approval to finish treatment was contraindicated as XXXX might lose the benefit achieved on the prior sessions. XXXX opined that XXXX would benefit from XX additional sessions of CPMP and XXXX would like to support XXXX to return to the workforce without risk of re-injury and / or be a risk for XXXX coworkers. Furthermore, XXXX also remarked that XXXX was motivated and receiving benefit from initial trial of CPMP.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

XXXX. The patient has undergone an initial XX hours of a CPMP and this request relates to another XX hours in order to continue therapy.

The documentation shows that XXXX has achieved some improvement from this CPMP, in that significant gains were made in XXXX XX. XXXX affect was improved and XXXX had no XX XX XX. Unfortunately, XX and XX XX persisted.

A functional capacity evaluation (FCE) was completed by XXXX. The patient manifested prominent XX limitations secondary to pain. An MRI of the XX was essentially XX. An MRI of the XX shows a partial XX and possibly some XX. A Designated Doctor Evaluation recommended increases attention to this XX.

Two prior Utilization Reviews failed to find any evidentiary grounds for approval of the additional CPMP. This reviewer agrees with their findings. However, notably, the patient should be able to manage XXXX XX symptoms on an outpatient basis. Additional CPMP sessions would have no benefit for the XX which has essentially improved. Given the documentation available, the requested service(s) is considered not 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 and Environmental Medicine

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
☐ DWC-Division of Workers Compensation Policies and Guidelines
☐ European Guidelines for Management of Chronic Low Back Pain
☐ Interqual Criteria
☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards

☐ Mercy Center Consensus Conference Guidelines

☐ Milliman Care Guidelines

☑ ODG-Official Disability Guidelines and Treatment Guidelines
ODG-TWC (ODG Treatment Integrated Treatment/Disability Duration Guidelines)
Pain (updated 11/16/2018)

Chronic pain programs (functional restoration programs)

XX
XX

☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance

Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.