



Specialty Independent Review Organization

DATE OF REVIEW: 04/27/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The service under dispute is a chronic behavioral pain management program of ten sessions length.

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

The reviewing physician is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation and has greater than five years of experience.

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)

The reviewer agrees with the previous adverse determination.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the requestor, the carrier and from MD. Records include the following: notes by MD from 2/14/03 through 2/7/07, 1/19/07 report LPC, operative reports MD 4/10/03 through 9/9/04, right knee bone scan report of 7/21/03, requests for reconsideration letters and CT scan of right knee of 7/7/03.

PATIENT CLINICAL HISTORY [SUMMARY]:

The above-mentioned patient was injured while employed . The injury occurred while the patient was lifting a frame and experience a pop in his back. The records also indicate that he suffered a knee injury as well for which he was surgically managed. However, the date of injury for the knee was not clear in the records. The report by LCSW on 7/28/05 notes the Beck's anxiety and

depression scales are abnormal. However, the report by Dr. indicates these same scales were 'unremarkable'.

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

The reviewer notes that the Official Disability Guidelines does support the usage of a pain management or behavioral management treatment program for certain lumbar conditions. The reviewer further notes that the documentation provided for review does not establish medical necessity for this type of procedure or program. This is because the documentation does not verify the presence of any significant lumbar pathology. Regarding a knee injury, the ODG does not support a program of this type for this type of condition.

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

- ACOEM- AMERICAN 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)