

C-IRO, INC.

7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Phone 512-971-5573
Fax 888-654-4116
Resolutions.manager@ciro-site.com
Medical Dispute Resolution

To: TDI

From: C-IRO, Inc.

Fax:

Pages:

Phone:

Date: August 8, 2007

Re: IRO Final Decision Letter

cc:

Comments:

facsimile

C-IRO, Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW:

AUGUST 7, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 5 x 6 weeks

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

A certification by the American Board of Physical Medicine and Rehabilitation with a specialty in 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRI of the lumbar spine, 04/28/06
Office evaluation Dr. 05/23/06
Operative report, 07/12/06
Office note, (partial), Dr. 04/06/07
Physical Performance Evaluation, 04/09/07
History and Physical, 05/30/07
Request for Services, 06/16/07
History and Physical, 06/18/07
Medical Review Determination, 06/29/07
Request for Reconsideration, 07/12/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a gentleman who was injured on the job. He was working as a when he twisted and felt a pop in his low back. He underwent physical therapy, which was not effective. He had an MRI and an EMG showing acute right L5 radiculopathy. He underwent lumbar disc surgery on 07/12/06 and subsequently a work hardening program. He has had persistent pain in his back and right leg and he has not returned to work. Pain at the time of his pain clinic evaluation was 4 out of 10 on 04/09/07. He reported decreased sleep, the ability to do 25 percent of his usual work, and pain which increased with standing, lifting, or walking.

His medications were Darvocet, Valium and Nexium. It does not appear that he has had a postoperative MRI, injection, anti-depressants or anti-seizure medications such as Neurontin or Lyrica.

IMPRESSION: Guidelines for the general use of multidisciplinary pain management programs indicate that an adequate and thorough evaluation has been made. It does not appear based on the records that he has had a significant postoperative evaluation. It also indicates previous methods of treating the chronic pain have been unsuccessful. This maybe true, but it does appear that he has had only very limited medication trials and no postoperative injections. For these two above reasons, he does not meet the criteria for the use of a multidisciplinary pain management program.

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

The chronic pain management program of five days a week for six weeks is determined not to be medically necessary. The main reasons are that he has not had an adequate postoperative evaluation for causes of his persistent pain and that he has not had reasonable trials of medical management of his pain.

Official Disability Guidelines: 2007 Updates: Pain

Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach:

- (a) The patient's response to treatment falls outside of the established norms for their specific diagnosis.
- (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis.
- (c) There is a previous medical history of delayed recovery.
- (d) The patient is not a candidate where surgery would clearly be warranted.
- (e) Inadequate employer support.
- (f) Loss of employment for greater than 4 weeks. The most discernable indication of at risk status is lost time from work of 4 to 6 weeks.

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

- (1) An adequate and thorough evaluation has been made.
- (2) Previous methods of treating the chronic pain have been unsuccessful.

(3) The patient has a significant loss of ability to function independently resulting from the chronic pain.

(3) The patient is not a candidate where surgery would clearly be warranted.

(5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change.

Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains.

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)**