

# IRO America Inc.

An Independent Review Organization  
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## **DATE OF REVIEW:**

12/28/07

## **IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Chronic pain management program for eight hours per day, five days per week, for two weeks

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

M.D., neurologist, fellowship trained in Pain Management, board certified in Neurology 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)

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

No ODG Guidelines  
Denial determination for requested service by dated 10/15/07 as well as 10/30/07  
Physician statement by dated 12/12/07  
Notes from dated 10/05/07  
Diagnostic interview and treatment plan by dated 09/20/07  
Various office notes from  
Letter from t dated 10/25/07  
Request for Appeal by dated 11/09/07

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant sustained a work-related injury on xx/xx/xx , resulting in some ongoing knee pain as well as spine pain, specifically lumbar spine pain. This claimant has undergone treatment with injections to the right knee, as well as some epidural steroid injections, a limited number of physical therapy visits (documentation indicates six visits total), usage of a TENS unit, and limited usage of analgesics including ibuprofen.

Imaging studies of the lumbar spine do indicate a spondylolisthesis at one level. There does not appear to have been any outpatient evaluations and/or treatment providing emotional or psychological intervention, nor does it appear that there has been any expert consultation by a pain specialist. The claimant is now retired, though there is a desire to increase functioning as far as activities on a daily basis.

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

It does not appear that this claimant has undergone the usual primary and secondary treatment consultations and modalities usually considered to be appropriate prior to the referral to a multi-disciplinary chronic pain management program. This would include the possibility of additional physical therapy beyond six visits, as well as possible consultation by a pain specialist for any ongoing significant pain, as well as any psychological consultations if needed; however, there is some question as to whether this claimant is in significant need for any psychological intervention, as a note by dated 09/20/07 indicates that, "The patient is not currently experiencing significant psychological symptoms. He appears to have well-developed coping resources and is independently utilizing appropriate pain management techniques." It is also noted in a separate document dated 10/05/07, also by, that the claimant "has not had any psychological testing, individual counseling, or biofeedback training for this injury." The Reviewer feels that the referral to a multi-disciplinary chronic pain management program, therefore, is premature, and agree with the previous denials for this particular requested service at this juncture.

**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)