

P-IRO Inc.

An Independent Review Organization
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Arlington, TX 76011
Fax: 866-328-3894

Notice of Independent Review Decision

DATE OF REVIEW:

12/26/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 5 x2

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

M.D., Board Certified in Pain Management and Anesthesiology

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

ODG Guidelines
Treatment Plan-10/5/07
FCE-9/27/07; 3/2/07
Radiology Rept.-10/15/06
10/16/06
Pain Ctr.-10/17/06
-10/26/06
.-2/21/07
MRI-3/27/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured while on the job on xx/xx/xx . Since that time, she has been suffering from low back and left knee pain. She has been involved in physical therapy for "two weeks." This physical therapy only aggravated her

pain. The patient has also never received any psychological testing, individual counseling or biofeedback training. It is also noted that the patient has received "bilateral injections" which provided her with 6-8 hours of pain relief. There is no mention as to what kind of injection was performed.

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

Per the *Official Disability Guidelines*, a patient is considered a candidate for a chronic pain management program if "previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement." It is noted that there has not been much done regarding interventional treatments. This patient has only received "bilateral injections." If she fails a multidisciplinary approach, then I would consider her a candidate for a chronic pain management program per the *Official Disability Guidelines*.

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)**