

IRO America Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Phone: 512-266-5815
Fax: 512-692-2924

DATE OF REVIEW:

JULY 19, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Twenty sessions of chronic Pain Management

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

MD Board Certified Anesthesiology 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office note, Dr.
Office notes, Dr., 05/14/07, 05/29/07
Office note, Dr., 05/18/07
Office note, Dr., 06/26/07
Letter, Dr., 07/05/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male who was injured when he jumped out of a moving car and injured his back, neck, left shoulder and left knee on xx/xx/xx. Ms. reviewed the medical records only for the purpose of appropriateness of recommendation to a chronic

comprehensive pain management program. Ms. noted that the 02/22/07 MRI of the lumbar spine showed a left posterior lateral and paracentral disc protrusion at L5-S1 with partial neural foramina encroachment. The 03/23/07 MRI of the left knee showed abnormal signal to the posterior horn of the medial meniscus. Electromyography reportedly showed sub acute left S1 radiculopathy. Ms. impression was pain disorder associated with both psychological factors, post traumatic stress disorder. Ms. felt that the claimant was appropriate for the program.

Dr. requested 20 sessions of pain management due to the following reasons; injuries sustained to the cervical and lumbar spine, left shoulder and knee; chronic pain functional deficits secondary to depressive reaction; inadequate pain and stress management skills; the need for aggressive intervention to control his depressive reaction; activities of daily living required assistance; average pain level of 8/10; and a failure to respond to conservative treatment consisting of psychotherapy, physical therapy, anti-inflammatory medications, muscle relaxants and narcotics. After receiving a denial for 20 sessions, Dr. requested a reconsideration noting functional deficits and primarily the same reasons as before. There were no physical exam findings provided in the reviewed documents.

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

Twenty sessions of chronic pain management would not appear to be medically necessary according to the information provided to me based and on ODG guidelines. The claimant is a male who had a previous MRI that demonstrated a left disc protrusion at L5-S1 with neuro foraminal encroachment. The claimant apparently had an EMG that demonstrated a consistent finding of S1 radiculopathy. The treating physician requesting the pain management has apparently authored multiple letters stating that the claimant has pain and functional problems as a result. The claimant has apparently been treated with multiple methods including therapy, medications, and psychotherapy. However, it is not clear whether the claimant has been refused as a surgical candidate for the objective pathology noted on the MRI or the EMG and nerve conduction study. The claimant clearly has objective pathology with S1 radiculopathy according to objective studies. There appears to be a large psychological component of his injury according to the note by Dr. 05/29/07. It is unclear whether the claimant has motivation to change as required by ODG guidelines and the claimant is noted to lack stress management skills. The benefit for improvement with a pain management program is doubtful. This claimant therefore, does not appear to follow all of the necessary criteria by ODG guidelines for a multidisciplinary pain management program.

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
Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Pain- Pain Management Program
- 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)