

C-IRO, Inc.

An Independent Review Organization
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Austin, TX 78726

IRO REVIEWER REPORT TEMPLATE -WC

DATE OF REVIEW:

JUNE 5, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management 10 sessions

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

M.D. Board Certified 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)

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

Peer review, Dr., 04/09/07
Peer review, Dr., 04/17/07
Lumbar spine MRI, 05/13/04
EMG/NCS, 05/24/04
Work hardening act sheet noted, 08/23/04
Office note, Dr., 09/20/04
Lumbar myelogram, 10/22/04
Office note, Dr., 01/24/05

Office notes, Dr., 05/04/05, and 01/18/07
Office note, Dr., 05/26/05
Office note, Dr., 06/20/05
Behavioral Health screening assessment, 02/14/07
Pain management/work hardening evaluation, 02/14/07
Pain Management case summary, 03/02/07
Pre-authorization letter, 03/05/07
Physical rehabilitation evaluation 03/07/07
Weekly progress report, 04./02/07 to 034/06/07
Request for continuation of formal treatment for Pain Management, 04/05/07
Letter of reconsideration for denial, 04/11/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This Patient reportedly had a low back injury after lifting a heavy box. The records indicated that the Patient continued to have post- traumatic pain including lower extremity radicular pain following the injury. An MRI done showed herniations at L4- 5 and L5- S1. The Patient treated conservatively throughout 2005 with medications, physical therapy, and epidural steroid injections. A physician record revealed the Patient still having back and right leg pain with no neurological deficits. Previous requested lumbar surgery in the form of a two level fusion was denied. A pain management program was recommended.

On 03/02/07 a pain management case summary noted the Patient had gained marginal insight and would likely require a more comprehensive program and would benefit from a pain management program to address chronic pain. Weekly progress reports noted the Patient with improved range of motion. An additional ten sessions of pain management has been requested.

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

This Patient has a history of a low back injury and is noted to have persistent back and right leg pain. There is MRI evidence of disc herniations at the L4-5 and L5- S1 levels. The Patient has undergone conservative care to include medications, physical therapy and epidural steroid injections. Surgery has been denied by the insurance company. The Patient has attended pain management sessions with improved range of motion however, additional pain management sessions were requested to help this Patient address his chronic pain.

The Reviewer would recommend an additional ten sessions of pain management for this Patient. The Patient was previously denied the pain management sessions by pain management physicians and previously denied surgery. If further conservative treatment is not undertaken it may drive this Patient to more invasive procedures and expensive care. The Reviewer would recommend ten additional pain management sessions for this Patient to address his chronic pain. The Patient should be made aware that the ten pain management sessions would exhaust his conservative management.

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
2007 Official Disability Guidelines, 12 edition, Integrated with Treatment Guidelines (ODG Treatment in Workers Comp, 5th edition)
- 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)