

**IRO REVIEWER REPORT TEMPLATE – WCN**

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**DATE OF REVIEW:** March 1, 2007

**IRO CASE #:**

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

Chronic pain management program times 20 sessions

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

Board-certified and specialized in Internal Medicine and Occupational 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)

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**

Case Assignment from TDI; medical records, letter, plans and goals from (10/24/06 through 2/20/07); medical records from (12/12/06 and 1/9/07); Medicine Center, Medical Records from Dr. (1/16/03 through 9/29/06).

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant injured his lower back in. He eventually underwent multi-level fusion. The indication for this extensive procedure is not provided. The hardware was removed in 1997. He underwent a chronic pain management program in 1997. The medical records provided do not document any improvement in objective or subjective parameters. The claimant had a spinal cord stimulator implanted with limited benefit. Current treatment consists of medications.

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

A review of the medical literature shows that the most effective treatment for chronic pain syndrome patients is by using an integrated interdisciplinary pain rehabilitation program. Patients should be accepted for treatment if there is indication that significant improvement in at least four treatment goals is achievable.

However, in this specific case, the claimant has already completed a chronic pain program with no short or long-term improvement. The literature does not support repeating such a program, regardless of the length of time that has passed since completing the first program.

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**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)