



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 05/16/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Thirty sessions of chronic pain management, five times a week for six weeks

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

Licensed by the Examiners

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

Work conditioning with an unknown provider (the signature was illegible) dated 01/02/06, 12/19/06, 12/20/06, 12/21/06, 12/22/06, 12/26/06, 12/27/06, 12/28/06, 12/29/06, 01/03/07, 01/04/07, 01/05/07, 01/08/07, 01/09/07, 01/10/07, 01/11/07,

01/12/07, 01/15/07, 01/16/07, 01/17/07, 01/18/07, 01/24/07, 01/25/07, 01/27/07, 01/31/07, 02/01/07, and 02/02/07

An evaluation with an unknown provider (no name or signature was available) dated xx/xx/xx

MRIs of the lumbar and thoracic spine interpreted by M.D. dated 06/09/06

A supply order from, D.C. dated 06/09/06

An evaluation with, M.D. dated 06/23/06

A letter from Dr. dated 06/23/06

Physical therapy with Dr. dated 06/26/06, 06/29/06, 07/07/06, 07/10/06, 07/30/06, 08/21/06, 08/23/06, 08/28/06, 08/30/06, 08/31/06, 09/05/06, 09/07/06, 09/11/06, 09/20/06, 10/04/06, 10/05/06, 10/09/06, 10/11/06, 10/13/06, 10/16/06, 12/12/06, 01/02/07, and 02/08/07

An EMG/NCV study interpreted by, M.D. dated 06/30/06

An evaluation with an unknown provider (no name or signature was available) dated 07/05/06

Evaluations with Dr. dated 07/05/06, 07/25/06, 08/30/06, 09/29/06, 11/02/06, 11/08/06, and 03/30/07

Evaluations with, M.D. dated 07/20/06, 08/29/06, and 10/30/06

Letters from, D.C. dated 07/21/06 and 11/09/06

A psychological evaluation with, M.A., L.P.C.-I dated 07/26/06

Functional Capacity Evaluations (FCEs) with Dr. dated 07/27/06, 10/24/06, and 02/05/07

An occupational therapy evaluation with, O.T.R. dated 08/09/06

Letters of medical necessity from Dr. dated 08/09/06

A request for authorization letter from Dr. dated 09/06/06

Evaluations with, M.D. dated 09/11/06 and 03/14/07

A Physical Performance Evaluation (PPE) with Dr. dated 09/15/06

Aquatic therapy with Ms. dated 09/18/06 and 09/20/06

Physical therapy requests from an unknown provider (no name or signature was available) dated 09/27/06 and 11/09/06

A peer review from, D.C. at dated 10/03/06

A Required Medical Evaluation (RME) with, M.D. dated 11/14/06

An evaluation with Dr. dated 11/30/06

Evaluations with (no credentials were listed) dated 12/14/06 and 02/01/07

A Designated Doctor Evaluation with, M.D. dated 02/07/07

A request for services from Mr. dated 02/14/07

A letter of non-certification from, Ph.D. at dated 02/21/07

A request for reconsideration letter from Dr. dated 02/22/07

A letter of non-authorization from, Ph.D. at dated 03/01/07

An evaluation with an unknown provider (only initials were listed) dated 03/07/07

A lumbar myelogram CT scan interpreted by, M.D. dated 03/12/07

A Request for Medical Dispute Resolution (MDR) from Dr. dated 05/01/07

PATIENT CLINICAL HISTORY [SUMMARY]:

Work conditioning was performed with Dr. from 01/02/06 through 02/02/07 for a total of 27 sessions. MRIs of the lumbar and thoracic spine interpreted by Dr. on 06/09/06 revealed disc protrusions at L3-L4 and L4-L5. On 06/23/06, Dr. prescribed Mobic. Physical therapy was performed with Dr. from 06/26/06 through 02/08/07 for a total of 23 sessions. An EMG/NCV study interpreted by Dr. on 06/30/06 revealed left L5 radiculopathy. On 07/20/06, Dr. requested a lumbar discogram. An FCE with Dr. on 07/27/06 indicated the patient functioned at the light physical demand level. Aquatic therapy was performed with Ms. Huber on 09/18/06 and 09/20/06. On 10/03/06, Dr. felt the patient would not require further chiropractic therapy. Another FCE with Dr. on 10/24/06 indicated the patient functioned at the light physical demand level. On 11/09/06, Dr. requested a six week work conditioning program. On 11/14/06, Dr. recommended epidural steroid injections (ESIs), an anti-inflammatory, work conditioning, a neuromuscular stimulator unit, and an FCE. On 12/14/06, Dr. also recommended a work conditioning program. An FCE with Dr. on 02/05/07 indicated the patient functioned at the medium physical demand level. On 02/07/07, Dr. felt the patient was not at Maximum Medical Improvement (MMI) and requested a myelogram CT scan and work conditioning program. On 02/14/07, Mr. requested 30 sessions of a pain management program. On 02/21/07, Dr. wrote a letter of non-certification for the pain management program. On 02/22/07, Dr. wrote a request for reconsideration letter. On 03/0/07, Dr. wrote a letter of non-authorization of the chronic pain program. A lumbar myelogram CT scan interpreted by Dr. on 03/12/07 was essentially unremarkable. On 05/01/07, Dr. requested an MDR.

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

Based upon the supplied documentation, it appears the patient's condition had progressed at a reasonable level. Towards the end of the treatment, he was complaining of pain levels of maximum 3/10, dropping as low as 1/10. Myelogram demonstrated the patient does not have any significant condition that would be expected to cause any lasting chronic pain. The patient is returned back to full duty work and there is no documentation indicating the patient is not able to function at that level. At the time of the request for chronic pain management program, it does not appear that the patient had exhausted all treatment options for his diagnosis. He was not taking ongoing medication and had decided to stop such medication of his own recourse, indicating the patient's condition must not have been significant. As previously mentioned, his condition continued to progress with the treatment provided.

Based upon the final understanding of his condition and the patient's subsequent return to full duty work, my findings are that the request for chronic pain management program five times a week for six weeks for a total of 30 sessions would not be reasonable or medically necessary.

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 AND KNOWLEDGE BASE**
- 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)**