

Notice of Independent Review Decision

DATE OF REVIEW: 10/18/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Pain management 5 x Wk x 2Wks.

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

This case was reviewed by a physician board certified in physical medicine and rehabilitation and pain medicine on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal.

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)

<i>Primary Dx Code</i>	<i>HCPCS/ NDC</i>	<i>Units</i>	<i>Begin/End Date</i>	<i>Type Review</i>	<i>Amt Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Uphold / Overturned</i>
722.1	97799		8/7/07-8/31/07	Prospective				Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for Independent Review by an Independent Review Organization forms – 9/27/07.
2. Determination Notices – 8/8/07 and 8/20/07.
3. Records and Correspondence– 3/8/07-8/10/07.
4. Records and Correspondence from DO – 6/19/07.
5. Records and Correspondence from Center – 6/16/06.
6. Records and Correspondence from Systems – 10/26/06.
7. Records and Correspondence from Medicine – 7/26/06.

8. Records and Correspondence from Evaluators MD – 1/22/06.
9. Records and Correspondence from DC – 2/3/05.
10. Records and Correspondence from Diagnostics – 2/2/07.

PATIENT CLINICAL HISTORY:

This case concerns an adult male who sustained a work related injury. Records indicate that while lifting an air conditioner, he felt a sharp pain in his low back. Diagnoses have included intervertebral disc disorder of the lumbar region, thoracic or lumbosacral neuritis or radiculitis, unspecified, and lumbago. Evaluation and treatment for this injury has included x-rays, pain medications, surgery, physical therapy, injections, massage therapy, and electrical stimulation.

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

The patient sustained a work related injury to his lower back while working for a roofing company. He is almost years post injury. He has undergone 3 low back surgeries, namely laminectomy at L4-5 on 3/12/04, repeat hemilaminectomy on 9/17/04 and decompression with fusion on 8/8/05. The medical records and documentation provided were reviewed in detail, including detailed history, CT scan results, RME report from Dr., second opinion from Orthopedics, peer review from Dr. and Dr., physical therapy notes, behavioral notes, etc. The requested chronic pain management is not medically indicated. Official Disability Guidelines (ODG) Pain chapter, ODG criteria for use of pain management programs has been used for this review. The patient has attended 20 pain management sessions to date. His notes show progress in the first 10 days of these sessions, but no significant change in the next 10 sessions, thus indicating him reaching a plateau with this treatment. An additional 10 sessions of pain management program services would not change his outcome and hence, is not 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 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 TCADA 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)**