



Specialty Independent Review Organization

## Notice of Independent Review Decision

**DATE OF REVIEW:** 10/22/07

**IRO CASE #:**

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

The service under dispute is a chronic pain management program 5 x 4 weeks or 20 total sessions.

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

The reviewer is a board certified Physical Medicine and Rehabilitation Physician with greater than 10 years of experience.

**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)

The reviewer disagrees with the previous adverse determination regarding 10 sessions of the requested program.

The reviewer agrees with the previous adverse determination regarding the last 10 sessions of the requested program.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: (URA) and Work and Accident Clinic (WAC).

These records consist of the following: WAC: SOAP notes from WAC 9/27/07, Chart notes by from 9/21/07 to 9/24/07.

(in addition to any previously mentioned records) 10/8/07 letter by, 8/20/07 precert request, CPM treatment and program design notes, 2/11/07 script for CPM, 7/25/07 eval by, PT, DO 7/31/07 note, CPM goals letter, 8/7/06 behavioral medicine consult and addendum, 2/28/07 cervical and thoracic MRI, 2/08/07 diagnostics by, MD and psychotherapy notes from 8/25/06 to 7/31/07.

(in addition to any previously mentioned records): 8/24/07 denial letter, 8/7/07 denial letter, pt insurance verification form, 1/16/07 PT eval, notes by Dr. 7/24/06 to 1/16/07, 6/16/06 lumbar MRI, 9/14/07 lumbar discogram/CT, 6/1/07 note by and 4/5/07 radiology reports,

We did not receive a copy of ODG Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured when he was bounced around a broom lift. He felt pain the following AM and reported to the company doctor. A lumbar MRI revealed DDD while an EMG was abnormal. He was managed with lumbar facet and ESI's which were not beneficial. He was treated with PT. Surgery and pain management have been proposed. He is currently not working.

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

The ODG guidelines indicate that a CPM program is recommended based upon the following support. Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: 1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating the chronic pain have been unsuccessful; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery would clearly be warranted; (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed.

Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains.

This injured worker qualifies for a CPM program based upon the above-mentioned criteria. The initial two weeks are approved pending his response to care. Additional care will need to be evaluated at that time.

**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)