

IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Fax: 817-549-0310

DATE OF REVIEW: 10-26-2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program 10 days

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

Doctor of Chiropractic- AADEP Certified

Whole Person Certified

TWCC ADL Doctor

Certified Electrodiagnostic Practitioner

Member of the American of Clinical Neurophysiology

Clinical practice 10+ years in Chiropractic WC WH Therapy

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

No ODG Guidelines

Request IRO form, MDR Request, Letter 9-24-2007 and 10-03-2007, Dr. DO letter 10-02-2007, request for 10 additional days of dated 9-18-2007, 9-20-2007, Initial 7-21-2006, Dr. report 5-22-2007, Team Conference reports, Dr. report 8-8-2006TNR report dated 4-23-2007, MRI lumbar spine 2-19-2007, C-T spine x-rays

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee was involved in an occupational injury on xx/xx/xx. The injured employee underwent advanced imaging and recommendations were made for either a vertebroplasty or kyphoplasty. The injured employee had completed 6 sessions once per week and then an additional 6 sessions over a period of 3 months. The employee had completed 17 sessions of pain management from 5-18-2007 thru 9-04-2007. An additional 10 sessions are currently recommended.

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

The injured employee has currently completed 17 sessions of chronic pain program and meets the criteria for the chronic pain program per National Guideline Clearinghouse, ACOEM, and TWCC. The injured employee is progressing under the current program. Therefore, an additional 10 sessions of chronic pain management would be considered reasonable and necessary at this 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**
 - **LISTED ABOVE**