

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

DATE OF REVIEW: OCTOBER 27, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program, 5 times a week for 2 weeks.

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

Board Certified in Psychiatry by American Board of Psychiatry and Neurology
Licensed to practice medicine by State of TX

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | | |
|-------------------------------------|---------------------|----------------------------------|
| <input checked="" type="checkbox"/> | Upheld | (Agree) |
| <input type="checkbox"/> | Overtured | (Disagree) |
| <input type="checkbox"/> | Partially Overtured | (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.

The reviewer finds that medical necessity does not exist for the proposed treatment, Chronic Pain Management Program, 5 times a week for 2 weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/9/07, 8/31/07
ODG Guidelines, Web Version, Pain, Updated 8/28/07, Chronic Pain Programs
Healthcare, Medical History, MPT, LPT, 6/23/05, 10/4/05, 7/20/07
6/23/05
Healthcare, Evaluation, 6/23/05
Healthcare, Evaluation, LPC-1, 7/20/07
LPC, 8/6/07
MD, Notes, 3/8/06, 9/6/06, 9/22/06, 1/10/07
Operative Report, 1/20/04
PPE Documentation Sheet, no date

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a woman who was injured at work on xx/xx/xx. Subsequently, her treatment has included 3 surgeries including a spinal cord stimulator. She has had chiropractic adjustments, physical therapy, e-stimulation, ultrasound, massage, stretching, heat/ice, topical analgesics. She also takes Celebrex, Darvocet and Vicodin. She has also participated in a multidisciplinary pain management program. Treating physician notes mild depression and anxiety and

subjective symptoms of depression. Treating physician requests approval of a chronic pain management program.

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

The UR reviewer was correct in denying authorization for a chronic pain management program. Treating physician states that on self-report questionnaires, the patient reported a mild level of depression and anxiety, however, the patient reported significant subjective symptoms of depression during the clinical interview.

ODG guidelines for such a program have not been met. The reviewer finds that medical necessity does not exist for the proposed treatment, Chronic Pain Management Program, 5 times a week for 2 weeks.

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)