

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

Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 29, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program x 20 Sessions

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

MD, Board Certified in Orthopedic Surgery

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.

The reviewer finds that medical necessity does not exist for Chronic Pain Management Program x 20 Sessions.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 6/27/08, 7/23/08
Physicians Ltd., 6/27/08, 7/23/08
8/15/08
ODG, Pain
Employers First Report of Injury
MD, 12/6/07
Workers Comp Interim Report, 7/14/08, 5/1/08, 6/4/08
Treatment Prescription, 7/31/08
Diagnostic Associates, 6/10/08
MD, 5/13/08

Psychological Evaluation, 3/4/08
MD, PhD, 3/12/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is an injured worker who apparently had injuries to her back and right knee on xx/xx/xx. She was standing on a stool. Her knee apparently gave way, and she started having pain in the right leg and low back. She was seen by Dr. and recommended physical therapy. Dr. prescribed medications. Subsequently, she saw Dr. who recommended injections. She also saw Dr. who re-read the MRI scan and found a herniation in variance to that which was reported by the radiologist, and also found various neurological problems that had not been documented by others. She complains of low back pain, apparently aching, and pins and needles into the thigh and right side. Medications have not helped. She apparently has pain with most activities. Physical examination by various examiners did not show significant abnormalities or neurological problems other than, in some cases, muscle spasm. Neurological examination including EMG/NCV study have been consistently negative except when she was examined by Dr. The MRI scan of the right knee showed no evidence of ligamentous or meniscal injury. An MRI scan of the lumbar spine revealed anatomical alignment and no spondylosis or fracture. At L4/L5 there is some flattening of the thecal sac with bilateral facet joint arthrosis and mild narrowing at the right neural foramina. EMG/NCV study was found to be normal. The diagnosis of back sprain and knee sprain were made consistently throughout the record. Dr. however, found that she had a positive flip test with significant muscle spasm. He documented on his read of the MRI scan that at L4/L5 there was a grade 2 disc herniation with an unstable motion segment, which was not mentioned by the radiologist who read the original images.

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

The patient does not meet the ODG criteria for a Chronic Pain Management Program x 20 Sessions. The guidelines recommend an initial 10 sessions of CPMP before considering the need for an additional 10 sessions. There is nothing in the medical records presented in this case to justify diverging from this guideline.

The reviewer finds that medical necessity does not exist for Chronic Pain Management Program x 20 Sessions.

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)