



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:
877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 12/17/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten sessions of chronic pain management

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

Board Certified in Anesthesiology
Fellowship Trained in Pain Management
Added Qualifications in Pain Medicine

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.

Ten sessions of chronic pain management – Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A Request for Services report from , Ph.D. dated 10/09/08
A Notice of IRO Decision from , President of ., dated 10/09/08
A request for a chronic pain management program from Dr. dated 10/09/08
A Request for Reconsideration letter from , D.C. dated 10/27/08
Letters of adverse determination, according to the ODG, from , Ph.D. dated 10/31/08 and 11/07/08
Reports from and , R.N. dated 10/16/08, 10/17/08, 10/31/08, and 11/07/08
A Functional Capacity Evaluation (FCE) with , M.D. dated 11/12/08
A psychological evaluation with , Ph.D. dated 12/01/08
A Medical Dispute Resolution (MDR) request from Dr. dated 12/10/08

PATIENT CLINICAL HISTORY

On 10/09/08, Dr. requested 10 sessions of a chronic pain management program. On 10/27/08, Dr. wrote a request for reconsideration for the pain program. On 10/31/08 and 11/07/08, Dr. wrote a letter of adverse determination for the pain management program. An FCE with Dr. on 11/12/08 indicated the patient functioned at the medium physical demand level and his job required the heavy physical demand level. On 12/01/08, Dr. recommended some supportive counseling and therapy. On 12/10/08, Dr. requested an MDR.

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

According to the ODG, tertiary levels of care, such as a chronic pain management program, are appropriate when all other reasonable medical treatment options and evaluations have been exhausted. It is not at all clear that this is the situation in this patient's case. According to psychologist, , the patient reported clinical benefit from injection therapy, yet there is no documentation as to why further injection therapy was not being considered. It is not at all certain that further injection therapy would not be beneficial to this patient and, therefore, that other medical treatment options exist. He also stated the patient was fully capable of undertaking short term job retraining, which would clearly obviate the need for vocational rehabilitation services within a chronic pain management program. Moreover, this patient has already failed to gain anything more than "minimal" benefit from all of the components of a chronic pain management program which were obtained through individual psychotherapy, physical therapy, and 20 sessions of a work hardening program. Therefore, there is no valid medical reason to expect that repeating those same components under the guise of a chronic pain management program, especially at the same facility which had provided work hardening and individual psychotherapy services, would provide this patient with any different clinical outcome. There is no medical reason or necessity to repeat treatment or components of treatment, which have already been proven to be without

significant clinical benefit. Furthermore, according to the ODG, chronic pain management programs should be undertaken in “programs with proven successful outcomes.” The request for 10 sessions of a chronic pain management at this facility does not include any documentation of outcome studies or whether, in fact, this program has “proven successful outcomes.”

Therefore, for all of the reasons above and according to the ODG and accepted standards of medical care and treatment, this patient is not an appropriate candidate for a chronic pain management program. The previous recommendations for non-authorization of 10 sessions of chronic pain management are, therefore, upheld.

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 AND KNOWLEDGE BASE
- 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)**