



# PROFESSIONAL ASSOCIATES

## Notice of Independent Review Decision

**DATE OF REVIEW:** 02/29/08

**IRO CASE #:**

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

Ten sessions of a chronic pain management program five times a week for two weeks

### **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 a chronic pain management program five times a week for two weeks - Upheld

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluations with, M.D. dated 05/18/07, 06/15/07, 07/02/07, 07/06/07, 07/20/07, 08/31/07, and 10/15/07

An operative report from Dr. dated 07/05/07

A Physical Performance Evaluation (PPE) with an unknown provider (no name or signature was available) dated 11/01/07

A behavioral medicine evaluation with, Ph.D. on 11/19/07

A preauthorization request from Dr. and, D.O. dated 12/11/07

An evaluation with, P.T. dated 12/18/07

A letter of non-certification, according to the ODG, from, Ph.D. dated 12/26/07

An appeal letter from Dr. dated 01/11/08

A letter of non-certification, according to the ODG, from, M.D. dated 01/17/08

A request for a review by an IRO from Dr. dated 02/12/08

An undated weekly schedule for a pain program

The ODG Guidelines were not provided by the carrier or the URA

## **PATIENT CLINICAL HISTORY**

On 05/18/07, Dr. recommended a hinged-knee brace and crutches. On 06/15/07 and 07/02/07, Dr. recommended right knee surgery. Right knee arthroscopic surgery was performed by Dr. on 07/05/07. On 08/31/07, Dr. recommended a home exercise program. On 11/19/07, Dr. recommended two weeks of an interdisciplinary pain management program. On 12/18/07, Ms. also requested 10 sessions of the pain management program. On 12/26/07, Dr. wrote a letter of non-certification for the pain management program. On 01/11/08, Dr. wrote a letter of appeal for the pain management program. On 01/17/08, Dr. wrote a letter of non-certification for the pain management program. On 02/12/08, Dr. requested an IRO.

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

Until the time that the patient was evaluated by the psychologist running the chronic pain management program on 11/19/07, there was absolutely no prior documentation of this patient having any psychological distress, psychological symptoms, or manifestations of psychological illness. Moreover, the medical

documentation clearly indicates that this patient has had no trial of anti-depressants nor, for that matter, any anti-inflammatory medication, a shortcoming noted by the orthopedist on his initial evaluation of 05/18/07. In fact, the patient appears to be taking nothing more than Hydrocodone, an opioid, and Flexeril, a muscle relaxant.

Therefore, it is abundantly clear to this reviewer that this patient has not exhausted all appropriate medical evaluation and treatment. Specifically, she has had no trial of anti-depressant medication and no recent follow-up with the orthopedic surgeon to address her alleged ongoing pain and weakness complaints. A chronic pain management program is not medically reasonable or necessary unless all appropriate medical treatment and evaluation has been exhausted. Therefore, in this case specifically, the request for a 10 sessions of a chronic pain management program five times a week for two weeks is not medically reasonable or necessary and the prior recommendations for non-authorization are 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)**