

Notice of Independent Review Decision

DATE OF REVIEW: 03-06-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Aftercare one session / month x 6 months

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

Certification by the American Board of Physical Medicine & Rehabilitation

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	722.93 724.4	97799	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Denial Notices, dated 12-07-07 and 01-03-08
Review Determination, dated 12-06-07, 12-31-07, 01-02-08
Behavioral Medicine Evaluation, dated 11-05-07
Chronic pain program physical therapy notes, dated 11-12-07
Letter of appeal for after care program, dated 11-12-07
Pre-authorization request, dated 11-12-07
Range of Motion Exam, dated 11-01-07
Letter of request for independent review, dated 02-12-08
Official Disability Guidelines (ODG) Pain - CPMP

PATIENT CLINICAL HISTORY:

The claimant is noted to be a xx-year-old lady with a three year history of low back pain. The date of injury was xx/xx/xx. It was noted that the claimant underwent a lumbar spine fusion. The evaluation of 11-05-07 suggests that a chronic pain program was completed. After this program, the practitioner requested an aftercare program.

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

In the opinion of the Reviewer, the chronic pain aftercare program is not medically necessary for this claimant. The claimant underwent a twenty-day program. The goals were laid out, but the outcome measurements were not met. Moreover, the success of this additional and excessive care is not listed. The article cited by the requesting practitioner notes that 20 sessions are maximum. Thus, with the stated goals not being met, with the documentation of successful outcomes not noted by the requesting practitioner, there is no data presented to suggest that any improvements are to be gained that could not be obtained with a comprehensive home-based, self-directed exercise program emphasizing overall conditioning and fitness. As noted in the ODG, unfortunately simply being a claimant may be a predictor of poor long-term outcomes. Thus, there is no reasonable expectation of any efficacy with this program.

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)