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## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 09/24/08

**IRO CASE #:**

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

Ten sessions of the PRIDE functional restoration program

### **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 the PRIDE functional restoration program - Upheld

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

A Required Medical Evaluation (RME) with, M.D. dated 04/22/08  
A letter from Dr. dated 05/06/08  
Evaluations with, M.D. dated 06/19/08 and 06/27/08  
A Functional Capacity Evaluation (FCE) with, P.T. dated 06/26/08  
A mental health evaluation with, M.S., L.P.C. and, Ph.D. dated 06/26/08  
A physical therapy evaluation with, P.T. dated 06/27/08  
Preauthorization notes from Dr. dated 07/10/08 and 07/25/08  
A letter of denial, according to the ODG, from, M.D. dated 07/11/08  
A reconsideration letter from Dr. dated 07/18/08  
A letter of denial, according to the ODG, from, D.O. dated 07/28/08

### **PATIENT CLINICAL HISTORY**

On 04/22/08, Dr. felt the patient could return to regular work duty and could be weaned to an anti-inflammatory. On 06/19/08, Dr. recommended an interdisciplinary program, possible knee injections, and a possible knee MRI. An FCE with Ms. on 06/26/08 indicated the patient was recommended for a pain management evaluation. On 06/26/08, Ms. and Dr. recommended a PRIDE program. On 07/11/08, Dr. wrote a letter of denial for 10 sessions of the PRIDE program. On 07/18/08, Dr. wrote a reconsideration letter for the PRIDE program. On 07/28/08, Dr. wrote a letter of denial for 10 sessions of the PRIDE program.

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

Chronic pain management programs are medically reasonable, necessary, and indicated when all lower levels of treatment have been exhausted and when there is evidence of needs such as decreasing a patient's intake of addicting medication or returning the patient to gainful employment. In this case, none of those criteria is present. The patient was clearly fully capable of gainful employment at his pre-injury job prior to a layoff after he switched jobs. There is no verifiable documentation that this layoff was in any way related to the patient's functional status. Secondly, this patient is taking only minimal amounts of Darvocet, certainly not sufficient to necessitate any intervention regarding decreasing the use of this medication, something that could simply and easily be done by simply stopping the medication. Finally, this patient, despite Dr. protestations, has certainly not exhausted all lower levels of care. For example, there has been no trial of anti-depressant medication nor any trial of lesser levels of psychological treatment, such as individual psychotherapy to deal with the patient's alleged psychological stressors. Those stressors, however, are documented by Dr. as being due to the fact that the patient was laid off from work, which does not appear any naturally occurring result of sequelae of the patient's injury. Additionally, despite Dr. assertion that the patient underwent "major surgery" for his knee, the patient, in fact, underwent nothing more than arthroscopic debridement of the knee, which would certainly not be, in my opinion, classified as a major surgery. As further support that this patient has not exhausted all appropriate medical treatment and evaluation, there is

documentation by Dr. in his initial evaluation of consideration of additional treatment such as injections or even surgery, which clearly indicates that medical treatment options remain for this patient.

The ODG indicates that outpatient pain rehabilitation programs may be considered medically necessary when ALL of the following criteria are met:

1. An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same tests can note functional improvement
2. Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement
3. The patient has a significant loss of ability to function independently resulting from the chronic pain
4. The patient is not a candidate where surgery or other treatments would clearly be warranted
5. The patient exhibits motivation to change and is willing to forego secondary gains including disability payments to affect this change
6. Negative predictors of success above have been addressed

Based on the entirety of the records provided for this review, the patient meets perhaps one or two of these criteria, but certainly not all of them. Therefore, per the ODG and medical standards of care, the request for 10 sessions of the PRIDE functional restoration program 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)