



---

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:** 04/07/09

**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**

## **PATIENT CLINICAL HISTORY**

On 02/29/08, Dr. recommended an EMG/NCV study. X-rays of the right shoulder and hip interpreted by Dr. on 02/29/08 showed mild osteoarthritis of the hip. An MRI of the cervical spine interpreted by Dr. on 03/10/08 showed a small disc herniation at C4-C5. Physical therapy was performed with an unknown therapist from 04/28/08 through 05/21/08 for a total of seven sessions. On 04/30/08, Dr. recommended continued physical therapy and samples of Skelaxin. Physical therapy continued with Ms. on

05/13/08 and 05/28/08. On 07/23/08, Dr. recommended a pain management referral, a neurosurgical consultation, an EMG/NCV study, an MRI of the right shoulder, and Darvocet. On 08/01/08, Ms. Speer recommended six sessions of individual psychotherapy. Individual therapy was performed with Ms. on 08/15/08 and 08/22/08. An MRI of the right shoulder on 09/04/08 showed degenerative changes, possible tendonitis, and a contusion. Individual therapy was performed with Ms. on 09/05/08 and 09/29/08. An EMG/NCV study interpreted by Dr. on 09/25/08 was unremarkable. On 09/30/08, Dr. felt the patient was not at Maximum Medical Improvement (MMI). An MRI of the lumbar spine interpreted by Dr. on 10/14/08 showed a disc protrusion at L4-L5 and lower lumbar spine facet arthrosis. An x-ray of the lumbar spine interpreted by Dr. on 10/14/08 showed mild wedging of L1 possibly related to Scheuermann's Disease. On 10/23/08, Mr. and Dr. recommended a work hardening program. Work hardening and group therapy were performed with Ms. and Ms. from 11/10/08 through 01/20/09 for a total of 19 sessions. An MRI of the thoracic spine interpreted by Dr. on 11/20/08 showed mild dextroscoliosis. On 12/12/08, Dr. wrote a letter of non-certification for the ESI. On 01/27/09, Mr. wrote a letter requesting 10 more sessions of the work hardening program. On 01/29/09, Mr. and Dr. recommended a chronic pain management program. On 02/09/09, Mr. recommended 10 sessions of a chronic pain management program. On 02/13/09, Dr. wrote a letter of non-certification, according to the ODG, for the pain management program. On 02/19/09, Dr. recommended an epidural steroid injection (ESI) and physical therapy. On 02/19/09, Ms. wrote a reconsideration request for the pain management program. On 02/26/09, Dr. also wrote a letter of non-certification for the pain management program. On 03/10/09, Dr. wrote a letter of non-certification for physical therapy twice a week for six weeks, according to the ODG.

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

This patient has completed at least four sessions of individual psychotherapy and 20 sessions of a work hardening program, as well as numerous physical therapy sessions. Despite exhaustive treatment, most, if not all, of the parameters measured and documented by the facility that has provided both individual

psychotherapy and work hardening, and now proposes to provide chronic pain management program services, indicate that the patient made no progress whatsoever from the treatment provided thus far. In fact, many, if not most, of the parameters measured indicated worsening of the patient's clinical condition. Additionally, despite referral to the chronic pain management program, this patient is continuing to undergo active treatment and evaluation with both an orthopedic surgeon and a chronic pain management physician; both of whom continue to recommend active medical treatment. A chronic pain management program is medically reasonable and necessary only if all other appropriate medical evaluation and treatment has been exhausted, which is clearly not the situation in this case. Moreover, the ODG treatment guidelines clearly indicate that it is inappropriate for a patient to undergo similar multidisciplinary programs when such programs have already been proven to be of no clinical benefit, which is clearly the case with this patient. The patient has had essentially all of the elements of a chronic pain management program provided to her through physical therapy, followed by individual psychotherapy, and then followed by 20 sessions of a work hardening program. Having gained no significant clinical benefit from any of that treatment, there is no medical likelihood that the patient would gain any benefit from a chronic pain management program, nor, therefore, any support in the ODG treatment guidelines. Based upon the entirety of the records provided for my review, the patient's lack of any objective evidence of significant pathology, the lack of corroboration of the patient's subjective symptoms by objective testing, and the lack of any significant clinical benefit from having already undergone a multidisciplinary rehabilitation program, there is no medical reason or necessity nor ODG treatment guideline support for this patient to now undergo 10 sessions of a chronic pain management program five times a week for two weeks. Therefore, the previous recommendations for non-authorization by two separate physician reviewers 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)**