



Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 3/30/09

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for 10 additional sessions of Chronic Pain Management.

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

Texas licensed Anesthesiologist

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.

The previously denied request for 10 additional sessions of Chronic Pain Management.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Fax Cover Sheet dated 3/20/09, 3/19/09, 12/23/08.
- Notice to, Inc. of Case Assignment dated 3/20/09.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 3/20/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 3/20/09.
- Request for a Review by an Independent Review Organization dated 2/9/09.
- Notice of Reconsideration dated 1/26/09.
- Referral dated 1/23/09, 12/29/08.
- Examination Findings Report dated 1/19/09.
- Request for an Appeal Letter dated 1/16/09.
- Notice of Denial of Pre-Authorization dated 12/30/08.
- Pre-Certification Request dated 12/23/08.
- Request for Pre-Authorization dated 12/22/08.
- Progress Note dated 12/15/08-12/5/08.
- Evaluation Report dated 10/22/08.
- Weekly Goal Sheet (unspecified date).

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years
Gender: Male
Date of Injury: xx-xx-xx
Mechanism of Injury: Motor vehicle accident.
Diagnosis: Left shoulder impingement, cervical and lumbar strain/sprain.

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

This male had a history of low back, neck, right hip and left shoulder pain since xx-xx-xx, when his truck fell off the road down a ditch. The claimant was a diagnosed with left shoulder impingement, cervical and lumbar strain/sprain. According to the 01/23/09 medical note, the patient had attended a pain program for 6 sessions and still experienced low back pain rated 7 on a 0-10 scale. He still had depression with anxiety with lack of confidence. He had treatment with physical therapy, a TENS unit and medications. The claimant was making good progress with improvement standing, walking, sitting, cardiovascular endurance, range of motion and pain. Despite this, he still had pain affecting his social, physical, psychological and occupational environments. He had not met his plateau from a physical or psychological perspective. He was on Zanaflex, Lidoderm and Hydrocodone. The request is now for 10 additional session of

chronic pain management. The ODG state "*Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (9) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that these gains are being made on a concurrent basis. Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program.*" As it was documented that the patient was making progress but has not met his plateau from a physical or psychological perspective, this request should be approved.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 6th Edition (web), 2008, Pain - **Criteria for the general use of multidisciplinary pain management programs:**

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).