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Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:  
877-738-4395

## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

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**DATE OF REVIEW:** 12/10/09

**IRO CASE #:**

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

Chronic pain management program five times a week for four to five 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.

Chronic pain management program five times a week for four to five weeks - Upheld

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

A Designated Doctor Evaluation with M.D. dated 02/19/09  
PLN-11 forms filed by the insurance carrier dated 04/15/09 and 10/29/09  
A peer review from, D.O. dated 09/01/09  
A mental health evaluation with, M.A., L.P.C.-I. and, Ph.D. dated 09/03/09  
An evaluation with D.C. dated 09/28/09  
A Functional Capacity Evaluation (FCE) with Dr. dated 10/08/09  
A peer review rebuttal from Dr. dated 10/09/09  
A BHI Enhanced Interpreted Report dated 10/14/09  
A Required Medical Evaluation (RME) with, D.O. dated 10/17/09  
An individualized daily treatment plan dated 10/28/09  
An evaluation with, M.S. and , M.S., L.P.C. dated 10/28/09  
A reconsideration request from Ms. dated 11/03/09  
A letter of non-certification, according to the Official Disability Guidelines (ODG), from, M.D. dated 11/05/09  
Letters of denial, according to the ODG, from dated 11/06/09 and 11/11/09  
The ODG Guidelines were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

On 02/19/09, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 5% whole person impairment rating. On 09/03/09, Ms. and Dr. recommended a pain management program. An FCE with Dr. on 10/08/09 indicated the patient only functioned at the sedentary physical demand level. On 10/17/09, Dr. recommended over-the-counter non-steroidal anti-inflammatories and a home exercise program. On 10/28/09, Ms. and Ms. recommended 10 sessions of a chronic pain management program. On 11/06/09 and 11/11/09, wrote letters of non-certification for the pain management program.

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

The patient has already undergone six sessions of individual psychotherapy, yet obtained no clinical benefit based on either equal or worse scoring on the Beck Depression and Beck Anxiety Inventory Scores, respectively. Therefore, there is clear evidence that this patient has not, and will not, respond to a psychological treatment regimen. These conditions are not generally responsive to psychological treatment and this patient's response to psychological treatment clearly proves that in this case. According to the ODG, any patient being considered for a chronic pain management program would not be appropriately admitted to such a program for more than five days initially to determine compliance and response to the program. Therefore, the current requested 20 to 25 sessions of a chronic pain management program clearly exceed that ODG

recommendations, as well as the ODG recommendation that no more than 20 sessions in total of a chronic pain management program be considered absent extenuating and extraordinary circumstances. This case certainly does not exhibit extenuating or extraordinary circumstances. In fact, this case exhibits minimal to no valid circumstances or conditions, in my opinion, that would require, necessitate, or support the requested five times per week for a four to five week chronic pain management program. Therefore, the previous recommendations by two separate physician advisors for non-authorization of the request are upheld and the request for a chronic pain management program five times a week for four to five weeks is not medically reasonable or necessary.

**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)**