



Notice of Independent Review Decision

**DATE OF REVIEW:** 2/26/09

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for ten sessions of a chronic pain management program.

**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 ten sessions of a chronic pain management program.

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

- Texas Department of Insurance Fax Cover Sheet dated 2/19/09.
- Note dated 2/19/09.
- Notice to CompPartners, Inc. of Case Assignment dated 2/19/09.

- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 2/18/09.
- Request Form/Request for a Review by an Independent Review Organization dated 2/9/09.
- Medical Determination Letter dated 2/4/09, 1/23/09, 1/8/09.
- Fax Cover Sheet dated 12/31/08.
- Pre-Certification Request Sheet dated 12/23/08.
- Evaluation Report dated 12/17/08.
- Physical Performance Evaluation Report dated 12/17/08.
- Office Visit Notes dated 10/6/08, 7/7/08, 6/30/08, 6/2/08.
- Operative Report dated 3/27/08.
- Texas Department of Insurance Guidelines (unspecified date).
- Company Request for IRO Information (unspecified date).

**No guidelines were provided by the URA for this referral.**

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** xx years  
**Gender:** xxxxx  
**Date of Injury:** xx/xx/xx  
**Mechanism of Injury:** Slip and fall

**Diagnosis:** Chronic knee pain.

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

This xx-year-old xxxx had a history of knee pain since xx/xx/xx, when she slipped in mud and hyperextended her knee. The patient was diagnosed with chronic knee pain. According to the 01/08/09 medical note, the knee pain was rated 5 on a 0-10 scale. The patient had mild anxiety and depression. On 12/17/08, it was stated that the patient was disabled since 1998. The patient was not able to stand for long periods of time and could only walk for short periods of time. It was recommended that the patient attend a pain program to control her pain at home, as there was no other surgical considerations stated in the records. The patient has had multimodality conservative treatment including medications, physical therapy, epidural steroid injection (ESI) and surgery. The patient had an evaluation with the conclusion that the patient was a good candidate for the program. The request is now for a chronic pain management program, 10 sessions. The Official Disability Guidelines 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: (1) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: (a) Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances; (b) Excessive*

*dependence on health-care providers, spouse, or family; (c) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (d) Withdrawal from social know-how, including work, recreation, or other social contacts; (e) Failure to restore pre-injury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f) Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or non-organic illness behaviors; (g) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (2) The patient has a significant loss of ability to function independently resulting from the chronic pain; (3) 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; (4) The patient is not a candidate for further diagnostics, injections or other invasive procedure candidate, surgery or other treatments including therapy that would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note functional and psychological improvement; (6) The patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect this change; (9) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented.” The patient meets the above criteria and the request for 10 sessions of chronic pain management program 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).