



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: 01/27/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Eighty Hours of Chronic Pain Management/Functional Restoration Program

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

Fellowship Trained in Pain Management
ABA Board Certified in Anesthesiology
Certificate of Added Qualifications in Pain Management

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.

EIGHTY HOURS CHONIC PAIN MANAGEMENT/FUNCTIONAL
RESTORATION PROGRAM

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An undated letter written "To Whom It May Concern" from

An MRI of the cervical spine interpreted by , M.D. dated 12/11/07
Evaluations with , M.D. dated 02/14/08, 06/03/08, 07/15/08, 08/28/08, 10/09/08, 11/18/08, and 12/18/08
Evaluations with M.D. dated 05/01/08, 09/25/08, 10/22/08, and 11/13/08
Laboratory studies dated 06/12/08
An enhanced MRI of the cervical spine interpreted by , M.D. dated 06/16/08
Mid term updates from an unknown provider (no name or signature was available) dated 06/16/08, 08/04/08, and 08/07/08
An impairment rating evaluation with , M.D. dated 06/18/08
A Functional Capacity Evaluation (FCE) with , M.D. dated 06/20/08
Group therapy with an unknown therapist (signature was illegible) dated 06/23/08, 06/24/08, 06/25/08, 06/27/08, 07/02/08, 07/07/08, 07/09/08, 07/10/08, 07/11/08, 07/14/08, 07/22/08, 07/23/08, 07/30/08, 07/31/08, 08/01/08, and 08/06/08
Massage therapy with an unknown provider (signature was illegible) dated 06/23/08, 06/25/08, 07/02/08, 07/09/08, 07/11/08, 07/22/08, 07/30/08, 08/01/08, 08/06/08, and 10/01/08
Physical therapy with , O.T.R. dated 06/23/08, 06/24/08, 06/25/08, 06/27/08, 07/07/08, 07/09/08, 07/10/08, 07/11/08, 07/14/08, 07/22/08, 07/23/08, 07/30/08, 07/31/08, 08/01/08, 08/06/08, and 10/01/08
Acupuncture with an unknown therapist (signature was illegible) dated 06/24/08, 06/25/08, 07/02/08, 07/09/08, 07/10/08, 07/23/08, 07/30/08, 07/31/08, 08/06/08, and 10/01/08
Individual psychotherapy with , M.A., L.P.C. dated 06/24/08, 07/02/08, 07/22/08, 07/30/08, 08/06/08, 08/28/08, 09/03/08, 10/01/08, 10/08/08, 10/15/08, and 10/22/08
A mid term update from Ms. xxxxxxxx dated 06/26/08
Physical Performance Evaluations (PPEs) with Ms. dated 07/02/08, 07/16/08, 08/04/08, and 10/31/08
Letters of approval, according to the Official Disability Guidelines (ODG), from , M.D. dated 07/22/08 and 08/07/08
A letter of approval from , Inc. dated 08/15/08
A letter from Dr. dated 10/06/08
An addendum report from , M.D. dated 10/13/08
An evaluation with , M.D., , M.D., Dr. , Ph.D., Ms. , Ms. , and , Clinic Coordinator dated 10/31/08
An evaluation with Ms. dated 10/31/08
A letter from Clinic Coordinator, dated 11/06/08
A letter of non-certification, according to the ODG Guidelines, from , M.D. dated 11/11/08
A prescription from Dr dated 11/13/08
An evaluation with Ms. dated 11/19/08
A letter of non-certification, according to the ODG Guidelines, from Ph.D. dated 12/01/08
An evaluation with , M.D. dated 12/05/08
A letter of approval, according to the ODG Guidelines, from dated 12/15/08
An MRI of the right shoulder interpreted by Dr. dated 12/19/08
An addendum letter from Dr. dated 12/23/08
A letter of denial, according to M.D. at dated 12/29/08
A rescheduling notification from Dr. dated 12/29/08

A letter from , Attorney, dated 12/30/08
A DWC-73 form from Dr. dated 01/02/09
The ODG Guidelines were provided by the carrier or the URA

PATIENT CLINICAL HISTORY

An MRI of the cervical spine interpreted by Dr. on 12/11/07 showed postoperative changes with a residual tumor and multilevel cervical spondylosis. An MRI of the cervical spine interpreted by Dr. on 06/16/08 showed a possible residual/recurrent tumor focus at C4. On 06/18/08, the claimant was placed at Maximum Medical Improvement (MMI) with a 31% whole person impairment rating. An FCE with Dr. on 06/20/08 indicated the claimant functioned in the sedentary physical demand level. Group therapy was performed from 06/23/08 through 08/06/08 for a total of 16 sessions. Massage therapy was performed from 06/23/08 through 10/01/08 for a total of 10 sessions. Physical therapy was performed with Ms. from 06/23/08 through 10/01/08 for a total of 16 sessions. Acupuncture was performed from 06/24/08 through 10/01/08 for a total of 10 sessions. Individual psychotherapy was performed with Ms. from 06/24/08 through 10/22/08 for a total of 11 sessions. On 07/22/08, Dr. wrote a letter of approval for six more sessions of chronic pain management sessions. On 08/28/08, Dr. recommended a TENS unit. On 11/11/08, Dr. wrote a letter of denial for 80 hours of a chronic pain management program. On 11/19/08, Ms. recommended the chronic pain management program. On 12/01/08, Dr. also wrote a letter of denial for 80 hours of the pain management program. On 12/05/08, Dr. recommended an MRI of the shoulder. An MRI of the right shoulder interpreted by Dr. on 12/19/08 showed a small subacromial spur, small bursitis/tendinosis, and a partial-thickness tear of the supraspinatus tendon. On 12/29/08, Dr. wrote a letter of denial for 12 sessions of physical therapy to the cervical spine. On 01/02/09, Dr. kept the claimant off work through 04/02/09.

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

This claimant has clearly had no significant functional improvement or sustained clinical benefit from the full twenty plus sessions of the chronic pain management program that she has already attended as well as six "after care" individual psychotherapy sessions. Per ODG treatment guidelines, absent extenuating or extraordinary circumstances no more than twenty sessions of a chronic pain management program are medically reasonable or necessary. In addition, there is absolutely no medical justification, reason, or necessity for any treatment that has not provided significant clinical benefit, for which it was intended, to be repeated. Clearly, this claimant did not have even mildly sustained or lasting clinical benefit from the chronic pain management program that she has already attended as her pain level BDI score, BAI score, and pain complaints all returned within weeks of completion of the chronic pain management program that she attended from 06/23/2008 through 10/22/2008. Obviously, therefore, there is no medical reason or necessity for repeating or continuing such ineffective treatment, especially when ODG treatment guidelines similarly recommend

against such treatment. There are clearly no extraordinary or extenuating circumstances regarding this claimant's case or clinical condition. Her continuing pain is not a reflection of such circumstances, but of treatment failure. Moreover, given the Functional Capacity Evaluation that was documented by Dr. , it is not, in my opinion, at all surprising that the claimant did not gain any clinically significant benefit from the chronic pain management program, as the results of that functional capacity evaluation clearly documented the claimant's submaximal, inconsistent, and nonphysiologic efforts and responses during that evaluation. Finally, this claimant is still being evaluated for primary and secondary levels of treatment, which clearly excludes consideration of a tertiary level of treatment, such as a chronic pain management program, according to ODG treatment guidelines. Therefore, there is absolutely no medical reason, necessity, or justification by either ODG treatment guidelines or normally accepted standards of medical care for this claimant to receive any further chronic pain management program sessions. The opinions of the two previous physician advisors recommending non-authorization of this request are, therefore, 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)**