



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)

DATE OF REVIEW: 07/24/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

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**

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 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the lumbar spine interpreted by, M.D. dated 10/30/07
A behavioral medicine evaluation with , M.S., L.P.C. dated 01/23/09
An evaluation with, M.D. on 05/14/09
A Functional Capacity Evaluation (FCE) with, P.T. dated 06/03/09
An evaluation with, M.D. dated 06/05/09
A request for a pain management program from, M.S., L.P.C. dated 06/11/09
A preauthorization request from Dr. dated 06/11/09
Letters of non-certification, according to the Official Disability Guidelines (ODG), from, R.N. dated 06/16/09 and 06/29/09
A letter of non-authorization, according to the ODG, from, M.D. dated 06/17/09
A reconsideration request from Mr. dated 06/24/09
A reconsideration request from Dr. dated 06/24/09
An environmental intervention note from, Ph.D. dated 06/29/09
A letter of non-certification, according to the ODG, from, Ph.D. dated 06/29/09
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

An MRI of the lumbar spine interpreted by Dr. on 10/30/07 revealed enhancing scar tissue at L4-L5 and a disc herniation at L1-L2. On 01/23/09, Ms. recommended a minimum of six weeks of individual psychotherapy. An FCE with Mr. on 06/03/09 indicated the patient functioned in the medium physical demand level. On 06/11/09 and 06/24/09, Mr. recommended 10 days of a chronic pain management program. On 06/17/09, Dr. wrote a letter of non-authorization for the pain management program. On 06/29/09, Dr. also wrote a letter of non-authorization for the pain management program.

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

According to the evaluation documented by Mr. in his initial request for 10 days of a chronic pain management program, the patient had a pain level of 3/10 and 40% to 50% reduction in self reported anxiety and depression as compared to her levels prior to six sessions of individual psychotherapy. The patient also reported minimal levels of frustration, tension, etc. In the medical evaluation by Dr., he specifically noted the patient's denial of both depression and anxiety and her normal mood and normal affect on examination. Therefore, by these criteria alone, the patient is not an appropriate candidate for a chronic pain management program as she manifests no evidence of psychological distress nor of consequences of psychological illness. Additionally, the request for a chronic pain management program as a comprehensive return to work effort is neither appropriate nor medically necessary as a chronic pain management program is not designed to be a return to work program. Work conditioning and work hardening programs are, however, designed for that purpose. Therefore, by this

criteria, the patient is also not an appropriate candidate for a chronic pain management program. Finally, chronic pain management programs are not medically reasonable or necessary unless all appropriate medical evaluations and treatment have been exhausted. In this case, the patient has not had either further evaluation or treatment of the MRI scan abnormalities identified on the most recent lumbar MRI scan of 10/30/07, which demonstrate epidural fibrosis with displacement of the thecal sac and compromise of the lumbar nerve roots. Therefore, by this criteria, the patient is additionally not an appropriate candidate for a chronic pain management program. Therefore, since the patient does not manifest any significant evidence of psychological distress or psychological illness, has not exhausted all appropriate medical evaluation or treatment (including no documented trials of anti-depressants), and has objective evidence of lumbar spine pathology which has not been adequately addressed or treated, she is not an appropriate candidate for a chronic pain management program. Therefore, the previous recommendations for non-authorization of the requested 10 sessions of a chronic pain management program are both 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)**