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## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 06/17/09

**IRO CASE #:**

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

An initial trial of 10 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 Psychology

### **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.

An initial trial of 10 sessions of a chronic pain management program - Overturned

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

#### **PATIENT CLINICAL HISTORY**

An MRI of the lumbar spine interpreted by Dr. on 04/10/07 revealed disc desiccation and a disc bulge at L4-L5 and perineural cysts at the approximate level of S2. On 04/20/07, Dr. recommended a trial of epidural steroid injections (ESIs). On 05/15/07, a PPE with Dr. indicated the patient functioned at the below

sedentary physical demand level. On 06/29/07, Ms. recommended six sessions of individual therapy. On 07/24/07, Dr. recommended an EMG/NCV study. On 08/06/07, 08/20/07, and 09/10/07, Dr. performed lumbar ESIs. Individual psychotherapy was performed with Dr. on 08/20/07 and 06/18/08. An MRI of the lumbar spine interpreted by Dr. on 10/23/07 revealed disc desiccation and a disc protrusion at L4-L5. On 11/16/07, Dr. felt the patient was a candidate for surgical intervention from a psychological standpoint. Lumbar surgery was performed by Dr. on 07/22/08. Further individual psychotherapy was recommended by Mr. on 10/14/08. Individual therapy was performed with Ms. and Mr. dated 11/12/08. Ms. and Mr. recommended a work hardening program on 12/03/08. Work hardening was performed on 12/26/08. On 01/22/09, Dr. recommended Neurontin and Robaxin. On 03/26/09, Dr. recommended a bilateral SI joint injection. On 03/31/09, Dr. recommended a chronic pain management program. Work conditioning was performed with Dr. on 04/03/09. On 04/07/09, Dr. requested a chronic pain management program. On 04/09/09, Dr. wrote a letter of adverse determination for 10 sessions of a chronic pain management program. On 04/13/09, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 10% whole person impairment rating. On 04/28/09, Mr. provided a reconsideration request for the pain management program. On 05/04/09, Dr. also wrote a letter of adverse determination for the pain management program. On 05/07/09, Dr. placed the patient at MMI at that time with a 0% whole person impairment rating.

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

The ODG states, "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 healthcare 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, and (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 diagnostic, injection(s) or other invasive or surgical procedure, or other treatments that would be warranted."
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." This was provided in the requesting doctor's documentation.
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."
7. "Negative predictors of success above have been addressed."

The requesting doctor clearly establishes the medical necessity of the request for an initial 10 days of treatment in a chronic pain program per the ODG and evidenced based guidelines. The requesting doctor provides an adequate and thorough evaluation that addresses psychosocial factors and treatment goals, as well as the appropriate literature citations establishing an adequate rationale for 10 days of treatment in a chronic pain program. All lower level care have been exhausted (previous methods of treating the chronic pain have been unsuccessful) and the patient remains unable to resume work at her prior level of functioning per the Designated Doctor. Therefore, the requested initial 10 sessions of a chronic pain management program are reasonable and necessary and the previous adverse determinations should be overturned.

**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)**