



DATE OF REVIEW: 6/9/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for Chronic pain management, 5 times a week for 2 weeks.

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

Texas licensed Anesthesiology/Pain Management Physician.

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 Chronic pain management, 5 times a week for 2 weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice to Inc. of Case Assignment dated 6/15/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 5/22/09.
- Request Form dated 5/19/09.
- Fax Cover Sheet/Comments dated 5/28/09, 5/26/09.

- Office Visit dated 5/6/09, 4/8/09, 3/25/09.
- Treatment History dated 5/29/09.
- Medication History dated 5/29/09.
- Treatment Service/Request dated 5/12/09, 4/28/09.
- Guardian Report dated 4/10/09.
- Pain Article dated 5/14/09.
- Request Form dated 4/15/09.
- Treatment Request dated 4/2/09.
- Texas Mutual Letter dated 5/29/09.
- Follow-Up dated 3/24/09.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Female

Date of Injury: xx-xx-xx

Mechanism of Injury: Lifting injury

Diagnosis: Postlaminectomy syndrome

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

This female had a history of neck pain since xx-xx-xx, from a lifting injury. The patient was diagnosed with postlaminectomy syndrome. According to the 05/26/09 medical note, there was neck pain that radiated into the shoulder. The pain was rated 5 on a 0-10 pain scale. There was numbness and paresthesias. She felt defeated and hopeless. The patient had associated sleep disturbances, poor appetite, depression, decreased memory, inability to relax, crying episodes, lack of motivation, symptoms of depression and poor concentration. There was no physical examination documented. The patient was on Norco and Zanaflex. The patient has had multimodality conservative treatment including medications and a cervical laminectomy 2-3 years ago. The patient had a fear of re-injury and wanted to get off her medications and go back to work. The patient had a psychological examination on 04/15/09, with recommendation for 10 sessions of a pain program. The request is now for 10 sessions of a chronic pain program. 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 preinjury 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 nonorganic 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; (7) Negative predictors of success above have been addressed; (8) These programs may be used for both short-term and long-term disabled patients. See above for more information under Timing of use; (9) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains.” The claimant’s psychotherapy treatments and any antidepressant medications were not discussed. The patient has not had a thorough multidisciplinary evaluation as of yet, therefore, this request is denied.

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).