

SENT VIA EMAIL OR FAX ON
May/12/2009

IRO Express Inc.

An Independent Review Organization

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DATE OF REVIEW:

May/06/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management Program 5 X 4

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC SURGERY

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 3/25/09 and 4/2/09

Clinic 3/23/09 thru 4/22/09

Mental Health Eval 3/17/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man who fell 4-6 feet on xx-xx-xx. He apparently sustained a ligament tear of the anterior talofibular ligament and possible tarsal tunnel syndrome. He has ongoing pain and depression and reportedly limited coping skills.

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

The records provided did not describe his walking limitations. One reviewer stated he was walking with a cane. He is on Darvocet and Cymbalta. There is a request for 20 sessions for pain management. The Reviewer could not determine the physical findings and the presence of any functional deficits. The Reviewer does not know the outcome from the therapies he had. Have the treating physicians determined that there is no treatable cause of the pain? The material provided was not clear if he is motivated to return to work, but presumably he is.

The ODG discusses mainly lumbar and cervical chronic pain treatment, but only touches on the lack of benefit for upper extremity problems. It did not discuss lower extremity chronic pain, including ankle pain.

If we presume he has the benefit of doubt that all treatment options have been considered and performed, and there are no further diagnostic studies, and that the lower extremity pain does respond to these programs, we would still be required to follow the ODG recommendations. First, the Reviewer is not clear what is his loss of function. Does he have or not have a normal gait? Is he deconditioned? Does he have fear avoidance? Again, even if we presume he met all the requirements cited and had none of the negative predictors, the request is for 4 weeks or 20 sessions. Criteria "(10) 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 Reviewer can only approve or deny the 20 sessions requested, yet the ODG advises an initial 10 with a reassessment. Therefore, the Reviewer cannot approve the pain program requested.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & 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

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)