

SENT VIA EMAIL OR FAX ON
Oct/01/2009

IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/25/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Pain Management 5 X wk X 2 wks

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 8/12/09 and 9/4/09

Injury xx/xx/xx

PPE 7/20/09

Dr. 7/2/09 thru 8/14/09

Psych Testing 1/8/09

Radiology Reports 10/16/08 and 3/8/08

Evaluations 11/13/08

Ortho 8/26/09

Records Sent 2008-2009

PATIENT CLINICAL HISTORY SUMMARY

This a female who was injured on xx/xx/xx when she twisted her low back lifting . Her work up showed degenerative changes on her MRI (9/08) and no evidence of disc herniations. The EMG (9/08) did not show a radiculopathy. She had physical therapy and psychotherapy. She is on Darvocet, Lyrica and Prozac. Her FCE showed her to be at a light PDL, but her job

requires a heavy PDL. After her treatment, she had worsening pain, irritability, frustration, tension, anxiety and forgetfulness. A decompression and fusion of a degenerative scoliosis, unrelated to her injury, is under consideration. She apparently was considered for work hardening, but I did not see that she entered a program.

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

The Reviewer has multiple concerns. One is that her symptoms worsened with treatment. As Mr., Mr., Dr., noted, she has no other treatment options for the lumbar strain. Dr. felt the symptoms are related to degenerative changes and not the injury. A surgical fusion is being considered for the scoliosis (independent of the work injury). After reading the different reports, the Reviewer is still not clear how much of the pain is from the strain and how much from the degeneration.

Mr. addressed paragraph by paragraph the ODG Criteria. My problem is that the Reviewer is having difficulty considering a patient for a chronic back pain program who will then have back surgery. On the other hand is the argument that there are not other treatments for the work related injury. One would generally contradict the other. Further, the Reviewer does not know directly what Dr. is planning to perform. The only resolution is a compromise based upon criteria 4 that permits a pain program to avoid surgery. Although the surgery is not for a work related problem, her pain symptoms may improve with the pain program.

ODG

Chronic pain programs (functional restoration programs)

(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.

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)