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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 03/29/10

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 Orthopedic 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)

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

A mental health & pain evaluation with M.D. dated 04/24/09
MRIs of the lumbar and thoracic spine interpreted by, M.D. dated 05/07/09
A procedure note from D.O. dated 06/03/09
Evaluations with M.D. dated 07/21/09 and 08/18/09
A Functional Capacity Evaluation (FCE) with D.C. dated 12/02/09
An individual treatment plan from M.A., L.P.C. dated 02/01/10
A follow-up visit with an unknown provider (no name or signature was available) dated 02/03/10
Evaluations with Dr. dated 02/05/10 and 02/19/10
A mental health evaluation with Mr. dated 02/15/10
A letter of non-authorization, according to the Official Disability Guidelines (ODG), from at dated 02/19/10
A letter of adverse determination, according to the ODG, from M.D. dated 02/19/10
A preauthorization request from Dr. dated 03/02/10
A peer to peer telephone conference note with Mr. z dated 03/04/10
A letter of non-authorization, according to the ODG, from R.N. at dated 03/08/10
A letter of adverse determination, according to the ODG, from Ph.D. dated 03/08/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 04/24/09, Dr. recommended a chronic pain management program, Baclofen, Hydrocodone, Acetaminophen, and Mobic. An MRI of the lumbar spine interpreted by Dr. on 05/07/09 showed a disc herniation at L5-S1 and a disc protrusion at L3-L4. An MRI of the thoracic spine interpreted by Dr. on 05/07/09 showed a disc bulge at T8-T9. On 06/03/09, Dr. performed a third lumbar epidural steroid injection (ESI). On 07/21/09, Dr. recommended a chronic pain management program. An FCE with Dr on 12/02/09 indicated the patient functioned at the light-medium physical demand level and a chronic pain management program was recommended. On 02/15/10, Mr. recommended 10 more sessions of a pain management program. On 02/19/10, Ms. and Dr. provided letters of adverse determination for 10 sessions of the pain management program. On 03/02/10, Dr. provided a preauthorization request for 10 sessions of a pain

management program. On 03/08/10, Ms. and Dr. also provided letters of adverse determination for the pain management program.

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

The patient has already undergone 10 sessions of a chronic pain management program at this time. The claimant's function has not improved and his medication usage has not decreased during these 10 sessions. There is no evidence presented or that will support that an additional 10 sessions will significantly improve this patient's function, change his medication use, or his need for further medical care. Therefore, the requested 10 sessions of a chronic pain management program are neither reasonable nor necessary and the previous adverse determinations should be 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)