



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:
877-738-4395

**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 07/23/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

40 hours of chronic pain management five times a week for one week

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

Licensed by the Texas State Board of Chiropractic Examiners

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.

40 hours of chronic pain management five times a week for one week - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A progress summary from, Ph.D., L.P.C. dated 04/15/10

Request for reconsideration letters from, D.C. dated 05/25/10 and 06/21/10

A letter of non-certification, according to the Official Disability Guidelines (ODG), from, D.C. dated 06/16/10

A letter of non-certification, according to the ODG, from, D.C. dated 06/30/10

A request for MDR from Dr. dated 07/12/10

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 04/15/10, Dr. provided a request for 10 additional sessions of a chronic pain management program. On 05/25/10 and 06/21/10, Dr. wrote reconsideration

request letters for five more sessions of the pain management program. On 06/16/10, Dr. wrote a letter of non-certification for five sessions of the pain management program. On 06/30/10, Dr. also wrote a letter of non-certification for five sessions of a pain management program. On 07/12/10, Dr. requested an MDR regarding the pain management program.

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

Based upon the ODG Guidelines, the patient is entitled to up to 20 visits of chronic pain management. It is not a guarantee of care and the condition is supposed to be assessed within two weeks of care, which it was. The patient showed very significant improvement in his condition, basically symptom free in several aspects of his condition, improved to the point where he was exercising for nearly one hour at a time without complications and was off his medications. Therefore, these findings indicate the patient no longer needs a chronic pain management program and the 15 day program was sufficient. Therefore, I recommend that the previous adverse determinations for the 40 hours of a chronic pain management five times a week for one week 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)