



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 07/30/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 Sessions Chronic Pain Management to Complete by 07/02/10

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

Board Certified in Physical Medicine & Rehabilitation

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.

10 Sessions Chronic Pain Management to Complete by 07/02/10 - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Job Description, Undated
- Medication Management, M.D., 08/10/09, 02/02/10
- Procedure Note, Dr., 08/10/09
- Follow Up Note, Dr., 08/24/09, 09/28/09, 11/02/09, 02/02/10
- Patient Referral and Intake Form, Healthcare Systems, 10/08/09
- Evaluation, M.A., L.P.C., 12/08/09
- Functional Abilities Evaluation, Rehabilitation Center, 12/08/09
- Basic Interpretive Report, Unknown Provider, 12/08/09
- Chiropractic Therapy, Health Systems, 01/11/10, 01/18/10, 01/25/10, 02/01/10, 02/08/10, 02/15/10, 02/22/10, 03/15/10, 03/22/10, 04/12/10, 04/19/10, 04/26/10, 05/03/10, 05/10/10, 06/02/10, 06/07/10, 07/05/10

- Physical Performance Evaluation (PPE), TX Evaluation Center, 03/06/10, 05/04/10
- Pre-Certification Request, Ms., 05/13/10
- Denial Letter, 05/21/10, 06/16/10
- Request for Appeal, Ms., 06/07/10
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The records available for review document that the patient sustained an injury in the workplace on xx/xx/xx. It was documented that on that date, the patient was attempting to. He slipped and sustained a fall. He was initially started on Lyrica, Amrix, and hydrocodone. An Epidural Steroid Injection (ESI) to the left L5-S1 level followed. The patient then received a Behavioral Health Assessment which indicated he was not currently working and “did not express a desire to return to work as he was retired.” It was documented that he was on the following prescription medications: Hydrocodone, Lyrica, Amrix, and Embeda. He then underwent approximately eighteen sessions of chiropractic treatment.

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

Based upon the records available for review, there would not appear to be an established medical necessity for treatment in the form of a comprehensive pain management program at the present time as it relates directly to the work injury of xx/xx/xx. The Official Disability Guidelines would not presently support such a request as one of medical necessity.

The prognosis for definitive benefit from such an extensive program is poor, given the fact that the patient is approaching xx years from the date of injury. Such a situation would certainly be considered a poor prognostic factor with respect to the potential for a positive response from treatment in the form of a comprehensive pain management program.

Additionally, the records available for review would appear to indicate that the patient’s symptoms are well controlled at the present time with treatment in the form of prescription medications. Consequently, the above noted reference would not support a medical necessity for a comprehensive pain management program for the described medical situation.

The records available for review indicate that when a behavioral health assessment was accomplished on 12/08/09, it was noted that the patient was “not currently working and did not express a desire to return to work as he is retired.” Such a situation would be considered a poor prognostic indicator with respect to the potential for it deriving positive benefit from treatment in the form of a comprehensive pain management program. The above noted reference would not support a medical necessity for pursuit of a comprehensive pain management program when it would not appear that there is a plan for the patient to return to any type of gainful employment, and when it would appear that

the patient's symptoms are well controlled with treatment in the form of utilization of prescription medications.

In conclusion, based upon the records available for review, the above noted reference would not support a medical necessity for a comprehensive pain management program for the described medical situation.

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 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)