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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 02/01/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Two weeks (80 hours) 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 Anesthesiology
Fellowship Trained in Pain Management
Added Qualifications in Pain Medicine

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.
Two weeks (80 hours) of a chronic pain management program - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A job description report dated 07/10/06
Evaluations with, M.D. dated 07/13/09, 07/28/09, 08/18/09, 08/25/09, 09/28/09, and 11/05/09
An x-ray of the lumbar spine interpreted by Dr. dated 07/13/09
An EMG/NCV study interpreted by, M.D. dated 09/11/09

A psychological evaluation with, M.A., L.M.F.T. dated 09/16/09
A Functional Capacity Evaluation (FCE) with, O.T.R. on 09/16/09
An MRI of the lumbar spine interpreted by, M.D. dated 10/01/09
A progress note from Ms. dated 10/14/09
A case manager note from dated 10/19/09
An evaluation with, M.D. dated 10/31/09
Computerized range of motion and physical testing dated 11/10/09 and 11/17/09
Work hardening dated 11/11/09, 11/18/09, and 11/25/09
Medication management dated 11/30/09 and 12/16/09
A Designated Doctor Evaluation with, M.D. dated 12/02/09
A letter of medical necessity from, M.D. dated 12/15/09
A prescription from Dr. dated 12/16/09
The ODG Guidelines were not provided by the carrier or URA

PATIENT CLINICAL HISTORY

On 07/13/09, Dr. took the claimant off work and prescribed unknown medications. On 08/18/09, Dr. recommended physical therapy. An EMG/NCV study interpreted by Dr. on 09/11/09 showed evidence suggestive of a right L4 radiculopathy and bilateral L5 radiculopathy. There was also evidence of possible trauma or entrapment of the right tibial and left peroneal motor nerves at the ankle and possible trauma or entrapment of the left tibial nerve in the lower leg. On 09/16/09, Ms. recommended a work hardening program. An FCE with Mr. on 09/16/09 indicated the claimant functioned at the sedentary-light physical demand level. An MRI of the lumbar spine interpreted by Dr. on 10/01/09 showed lumbar spondylosis that was worse at L3-L4. Work hardening was performed on 11/11/09, 11/18/09, and 11/25/09. On 12/02/09, Dr. felt the claimant was not at Maximum Medical Improvement (MMI) and recommended an evaluation with a spine specialist. On 12/15/09, Dr. wrote a letter of medical necessity for a chronic pain management program.

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

This patient is absolutely not a valid candidate for consideration of a chronic pain management program. He has clearly not exhausted all appropriate medical treatment options. In fact, it appears that the only treatment provided for this patient has been non-specified physical therapy and a nine day trial of a work hardening program. Work hardening programs are not meant for patients who still have significant pain but only for patients who are ready for return to work but need the extra physical and psychological attention to attain that goal. This patient at the onset of the work hardening program still had the same severe subjective pain complaints as he did after his lumbar strain injury on 07/13/09 and was clearly not an appropriate candidate for consideration of a return to work program. Additionally, despite Dr. assertion that the patient has significant psychological issues to necessitate a chronic pain management program, objective testing by his own staff clearly contradicts that statement. The patient is not on any medication at a sufficient dose to cause concern or provide necessity for "medication management" in a chronic pain management program.

That “medication management” can easily be accomplished by Dr. in simple regular office visits, especially given the minimal amount of medication that the patient is allegedly taking. There being no evidence that this patient has had any evaluations other than by Dr. clinic and EMG testing, it is abundantly clear that the patient has not exhausted all appropriate medical treatment or evaluation options. For all the reasons described above, therefore, the request for two weeks (80 hours) of a chronic pain management program is not medically reasonable or necessary. This patient does not meet ODG criteria for admission to such a program and needs to receive appropriate treatment per the ODG Treatment Guidelines. Therefore, I recommended that the previous adverse determinations be upheld and two weeks of a chronic pain management program would not be reasonable or necessary.

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

- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

- MILLIMAN CARE GUIDELINES

- X 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)