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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 06/24/10

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 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.

Ten sessions of a chronic pain management program - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An oximetry test dated 04/24/07

An MRI of the thoracic spine interpreted by, M.D. dated 07/09/07

A procedure report from, M.D. dated 08/21/07

A Required Medical Evaluation (RME) with, M.D. dated 04/15/09

Evaluations with, P.A.-C. and Dr. dated 09/17/09, 10/20/09, 11/19/09, and 12/21/09

Evaluations with, D.O. dated 01/19/10 and 02/16/10

An evaluation with, Ph.D. dated 03/04/10

A Physical Performance Evaluation (PPE) with, D.C. dated 03/08/10

A precertification request from, L.P.C. dated 03/10/10

A letter of denial, according to the Official Disability Guidelines (ODG), from, L.V.N. dated 03/22/10

A request for an appeal from Rehabilitation Center dated 03/31/10

A letter of denial, according to the ODG, from, Ph.D. dated 04/09/10

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

PATIENT CLINICAL HISTORY

An MRI of the thoracic spine interpreted by Dr. on 07/09/07 was unremarkable. On 08/21/07, Dr. performed a dual lead spinal cord stimulator trial. On 04/15/09, Dr. recommended continued maintenance treatment for the back including monthly visits and medication refills for an indefinite period of time. On 10/20/09, Ms. and Dr. provided refills of MS Contin, Lortab, Neurontin, and Effexor XR. On 03/04/10, Dr. requested 20 sessions of a chronic pain management program. A PPE with Dr. on 03/08/10 indicated the patient functioned in the medium heavy physical demand level and a pain management program was recommended. On 03/10/10, there was a precertification request for 10 sessions of a pain management program. On 03/22/10, Ms. wrote a letter of denial for the pain management program. On 03/31/10, Rehabilitation Center wrote a request for appeal for a pain management program. On 04/09/10, Dr. also wrote a letter of denial for the pain management program.

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

It does not appear at this point in time that this patient is a candidate for 10 sessions of a pain management program. The patient obviously has failed primary, secondary, and tertiary levels of care and has most recently been receiving maintenance management, which appears to be quite appropriate for such a chronic condition. The patient had been managed by Dr. appropriately with office visits to oversee a home exercise regimen, to oversee medication management, and to assess for any side effects and address any further disabilities. The request for 10 sessions of a pain program is based on Dr.'s belief that the patient would benefit from some exercises, improving her psychological status, and addressing any other continued functional deficits. I do not see any treatment recommendations with regards to weaning the patient off of her narcotics and opiates. I do not find the program to be compatible with the necessity for this patient at this time in terms of managing her pain. The patient has retired and return to work is not a goal stated by the patient. There are no functional objectives that are to be addressed by this treatment program, except for improving some range of motion and overall wellbeing. Therefore, the requested 10 sessions of a pain program would not be appropriate or consistent with the recommendations per the ODG 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)