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Notice of Independent Review Decision

DATE OF REVIEW: 03/15/10

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 - Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An Emergency Department Triage Record from an unknown provider (signature was illegible) dated 09/16/09
CT scans of the cervical spine and head interpreted by D.O. dated 09/16/09
X-rays of the cervical spine and right shoulder interpreted by Dr. dated 09/16/09
Evaluations with M.D. dated 09/21/09 and 11/16/09
DWC-73 forms from Dr. dated 09/21/09 and 11/16/09
Physical therapy with P.T. dated 10/19/09, 10/21/09, 10/23/09, and 10/26/09
A physical therapy progress report from Mr. dated 10/26/09
Evaluations with M.D. dated 10/30/09, 11/11/09, 12/02/09, 12/18/09, 01/20/10, and 01/22/10
Quantitative Functional Capacity Evaluations (FCEs) with P.T. and, L.O.T. dated 11/02/09 and 01/22/10
A mental health evaluation with, M.S., L.P.C. and, Ph.D. dated 11/09/09
Evaluations with an unknown provider (signature was illegible) at Family Medicine dated 11/16/09, 12/15/09, 01/14/10, 02/04/10, and 02/19/10
DWC-73 forms from M.D. dated 11/16/09, 12/15/09, 01/14/10, and 02/04/10
An MRI of the brain interpreted by M.D. dated 11/17/09
Reconsideration letters from Dr. dated 12/02/09 and 02/05/10
Physical therapy with, P.T. dated 12/14/09, 12/18/09, 01/04/10, 01/08/10, 01/11/10, and 01/15/10
Physical therapy with P.T. dated 12/16/09, 12/21/09, 01/06/10, and 01/13/10
An approval request from Dr. dated 01/27/10
A letter of non-authorization, according to the Official Disability Guidelines (ODG) from M.D. dated 02/01/10
Letters of denial, according to the ODG, dated 02/02/10 and 02/10/10
A reconsideration request from Dr. dated 02/08/10
A letter from the patient dated 02/22/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

CT scans of the cervical spine and head interpreted by Dr. on 09/16/09 showed a stable posterior spinous process fracture at C6 only. X-rays of the right shoulder interpreted by Dr. on 09/16/09 showed a previous right shoulder rotator cuff repair. On 09/21/09, Dr. provided a soft cervical collar and recommended physical therapy. Physical therapy was performed with Mr. on 10/19/09, 10/21/09, 10/23/09, and 10/26/09. An MRI of the brain interpreted by Dr. on 11/17/09 showed mild volume loss and probable chronic small vessel ischemic change. On 12/02/09, Dr. provided a Toradol injection. Physical therapy was performed with Ms. from 12/14/09 through 01/15/10 for a total of six sessions. Physical therapy was also performed with Ms. on 12/16/09, 12/21/09, 01/06/10, and 01/13/10. On 01/22/10, Dr. recommended a PRIDE program. On 02/01/10, Dr. wrote a letter of non-authorization for the pain management program. On 02/02/10 and 02/10/10, wrote letters of non-authorization for the pain management program. Dr. wrote a reconsideration letter on 02/05/10.

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

The patient had a relatively low energy injury. His course has been complicated by his depression, anxiety, and pain, which is out of proportion to the objective physical findings. The patient has failed to respond with an adequate trial of physical therapy and some psychological support. Based upon my review of the Official Disability Guidelines (ODG) and the clinical records, this individual does meet the criteria for a chronic pain management program, having not met his job requirements and having anxiety and depression as a complicating issue. Therefore, the requested 10 sessions of a chronic pain management program would be reasonable and necessary and therefore, the previous adverse determinations should be overturned.

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)