



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: 05/05/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management “after care program”, four hours per monthly session for six months

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

on 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.

Chronic pain management “after care program”, four hours per monthly session for six months - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A behavioral medicine evaluation with, Ph.D. dated 01/11/10
A physical assessment evaluation with, M.D. dated 01/13/10
A Functional Capacity Evaluation (FCE) with Dr. dated 01/18/10
A multidisciplinary chronic pain management physical therapy goals sheet from, D.C. dated 01/18/10
A preauthorization request from Dr. and Dr. dated 01/18/10
A letter of denial for a chronic pain management program, according to the Official Disability Guidelines (ODG), from, M.D. dated 02/12/10
A letter of appeal from Dr. and Dr. dated 03/02/10
A letter of denial, according to the ODG, from, Ph.D. dated 03/12/10
A request for an IRO from Dr. dated 04/12/10

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

PATIENT CLINICAL HISTORY

On 01/11/10, Dr. requested an interdisciplinary pain management program. An FCE with Dr. on 01/18/10 indicated the patient functioned at the light physical demand level. On 02/12/10, Dr. wrote a letter of non-authorization for the chronic pain management program. On 03/02/10, Dr. and Dr. wrote a letter of appeal. On 03/12/10, Dr. wrote a letter of denial for the pain management program. On 04/12/10, Dr. requested an IRO.

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

At this time, based upon the criteria provided in the ODG for a chronic pain management program, there is no justification for continuing this program. The patient did achieve some of his goals during his time in the program. He is continuing to attend his educational activities without any interference. He has not been significantly detoxified from his medications with only slight decrease in his narcotic usage. It does not appear that significant functional gains were made during his chronic pain management program. It is unclear what six additional months of follow-up would do to change his pain complaints. Therefore, based upon the fact that significant gains were not made and the patient does not meet the criteria as outlined in the ODG, the recommended chronic pain management "after care program", four hours per monthly session for six months is neither reasonable nor necessary 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
- 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)