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## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

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**DATE OF REVIEW:** 05/13/10

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

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 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.

80 hours of a chronic pain management program - Upheld

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

A mental health evaluation with Ed., L.P.C. and M.D. dated 02/22/10  
A Functional Capacity Evaluation (FCE) with Dr. dated 02/24/10  
Preauthorization request letters from Dr. dated 03/26/10, 03/29/10, and 04/06/10  
A letter of adverse determination, according to the Official Disability Guidelines (ODG), from M.D. dated 03/26/10  
A request for reconsideration letter from Dr. dated 04/05/10  
A letter of adverse determination, according to the ODG, from M.D. dated 04/05/10  
A letter of appeal from Dr. dated 04/30/10

## **PATIENT CLINICAL HISTORY**

On 02/22/10, Ms. and Dr. recommended 10 sessions of a chronic pain management program. An FCE on 02/24/10 indicated the patient functioned at the light physical demand level. On 03/26/10, 03/29/10, and 04/06/10, Dr. wrote letters of preauthorization request for the chronic pain management program. On 03/26/10, Dr. wrote a letter of adverse determination for the pain management program. On 04/05/10, Dr. wrote a reconsideration request letter for the pain management program. On 04/05/10, Dr. wrote a letter of adverse determination. On 04/30/10, Dr. wrote a letter of appeal for the chronic pain management program.

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

This patient sustained a relatively minor injury. The results of prior treatment are not summarized in the records I reviewed, such as physical therapy, anti-depressant medications, or a trial of return to work. It is not clear why the patient would not improve with a work conditioning program or what would exclude him from a trial of return to work. These have not been discussed in the documents I reviewed. Therefore, the patient does not meet the criteria provided by the Official Disability Guidelines (ODG) for entrance into a chronic pain management program. The patient has not failed all lower levels of care and the rationale for this most expensive and all consuming care has not been adequately provided. Therefore, the requested 80 hours of a chronic pain management program would not be reasonable or 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
- 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)