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Notice of Independent Review Decision

DATE OF REVIEW: May 10, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Ten visits of chronic pain management.

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

AMERICAN ASSOCIATION OF NEUROMUSCULAR AND ELECTRODIAGNOSTIC MEDICINE and CERTIFIED PAIN MANAGEMENT.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- xxxxxx, 01/05/09, 01/21/09, 02/03/09, 09/23/09, 10/29/09, 11/02/09, 11/05/09, 11/06/09, 11/09/09, 11/11/09, 11/13/09, 11/16/09, 11/18/09, 11/23/05, 11/25/05, 11/27/09, 11/30/09, 12/14/09, 12/21/09, 12/28/09
- xxxxx, Inc., 02/05/09, 03/03/09, 09/28/09, 11/20/09, 12/31/09, 01/04/10, 01/11/10, 01/18/10, 01/25/10, 02/01/10, 02/08/10, 03/23/10
- xxxxx, 12/16/08, 12/10/09, 02/01/10, 03/18/10
- Texas Department of Insurance, 04/26/10

Medical records from the Provider include:

- DFW MRI, 06/19/07
- M.D., 08/06/07, 09/24/07, 11/27/07, 11/17/08, 01/15/09, 07/20/09, 06/22/09, 07/27/09, 08/25/09, 09/14/09
- xxxxxx, 11/02/07
- xxxxxx, 05/13/08

- xxxxx, 12/16/08, 03/03/09, 03/10/09, 09/23/09, 09/30/09, 02/01/10
- xxxxx, 08/25/09
- D.C., 09/28/09, 01/26/10
- xxxxx, 01/26/10, 01/29/10, 02/22/10
- xxxxx, 02/03/10, 03/03/10
- Request for a Review by an Independent Review Organization, 03/15/10
- Texas Department of Insurance, 04/23/10

PATIENT CLINICAL HISTORY:

The description of qualifications: The IRO reviewer is a Texas licensed specialist, board certified in physical medicine and rehabilitation with over 30 years of the private practice of physical medicine and rehabilitation.

The review outcome is upheld.

This patient, who was originally injured on xx/xx/xxxx was carrying furniture with the onset of low back pain.

The patient appears to have continued to work until July 3, 2007, when he sought medical care and underwent surgery consisting of an L5-S1 lumbar fusion on September 27, 2007. The patient subsequently was recommended for work hardening and reportedly had additional surgery performed. It is noted that he had prior chronic pain management during February and March of 2009.

The patient had been seen for a designated doctor evaluation on May 13, 2008, and was certified as having reached maximum medical improvement on March 13, 2008, with a 5% whole person impairment rating.

The patient has just completed a program of 20 work hardening sessions and immediately referred for a chronic pain management program. The patient was requested ten initial treatments of a chronic pain management program, which was denied, and then a reconsideration appeal was also denied, utilizing ODG criteria.

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

The decision to uphold the original denial is based on failure to meet the criteria noted in the ODG for a tertiary return to work program, such as a multidisciplinary chronic pain management program. This is based on the criteria that moving from one return to work program immediately or in close proximity to another return to work program is not in keeping and not medically necessary by evidence based medical standards. Another component is the likelihood of benefit from participation in a return to work program, such as a multidisciplinary chronic pain management program. As the patient has gone through a full work hardening return to work program and immediately requested for a pain management program would not be in keeping with the ODG criteria.

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)**