

C-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/24/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97799 Addtl Chronic Pain Management Program x 10 Days

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

MD, Board certified in Physical Medicine and 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG-TWC Treatment Guidelines

URA Letters, 3/23/10, 4/20/10

Injury 1 2/25/09 to 4/13/10

D.O. 1/26/09 to 3/15/10

FCE 2/22/10, 10/8/09, 8/26/09, 2/22/10

10/13/09

Chronic Pain Functional Restoration Programs (undated)
5/6/10

Medicine Associates 9/29/08, 10/20/08, 11/3/08, 11/17/08,
12/1/08, 12/18/08, 1/14/09

Diagnostics 3/12/09

D.O. 4/9/09, 5/7/09, 6/4/09

M.D. 6/3/09

D.C. 4/27/09

Work Hardening Program 9/28/09 to 10/14/09

Natural Corrections 11/20/09

Chronic Pain Management Program Notes, 2/8/10 to 2/24/10

PATIENT CLINICAL HISTORY SUMMARY

This 5'7", 210 pound worker has a date of birth of xx/xx/xx. His job was as a xxx at xxxx. He experienced back pain while pulling and stacking boxes. The event was unwitnessed. He was on Lyrica and Tramadol and these have been stopped. He uses Celebrex and Amrix.

He has had PT, work hardening, chiropractic care and recently 10 days of a chronic pain program. His pain is unchanged after 10 days of the pain program. His BDI increased from 8 to 10. He has increased from a light/medium work level to a medium work level. His job requires heavy work. MRI shows L4/5, L5/S1 HNP. He is not a surgical candidate.

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

According to the records, this patient is capable of light medium work but has not returned to some type of gainful employment. He has participated in a work hardening program and there is no indication he attempted to return to work following that program. He was enrolled and participated in 10 days of a chronic pain program. There is not evidence of significant improvement. Chronic pain programs are recommended where there is access to programs with proven successful outcomes, such as decreased pain and medication use, improved function and return to work and decreased utilization of the health care system. There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. The patient should show evidence of motivation to improve and return to work and meet the selection criteria. The predictors of failure in a CPP are poor work adjustment and satisfaction, a negative outlook about future employment, high levels of pretreatment depression, pain and disability, increased duration of pre-referral disability time, higher levels of opioid use and elevated pre-treatment levels of pain.

This patient does not meet criteria for continuation in the pain program. There is not evidence of motivation to improve and return to work. There are higher pretreatment levels of pain and depression. The reviewer finds that medical necessity does not exist for 97799 Addtl Chronic Pain Management Program x 10 Days.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)**