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Notice of Independent Review Decision

DATE OF REVIEW: 10/20/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program five times a week for two weeks

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.

Chronic pain management program five times a week for two weeks - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Rehabilitation progress notes from L.M.T., C.P.T., and Rehab Tech dated 12/30/09, 01/08/10, 01/12/10, 01/15/10, and 01/21/10

A behavioral medicine consultation with L.P.C. dated 01/12/10

Interdisciplinary program team conferences with D.O., P.A., L.P.C.-I., D.C., and Mr. dated 03/29/10, 04/05/10, 04/12/10, 06/07/10, 06/14/10, 06/21/10, and 07/06/10

A Functional Capacity Evaluation (FCE) with Dr. dated 07/14/10

An evaluation with Ms. and Ph.D. dated 07/14/10

Psychological testing with Psy.D. and Dr. dated 07/28/10

Requests for a chronic pain management program from Dr. dated 08/19/10 and 09/08/10

A letter of non-certification, according to the Official Disability Guidelines (ODG), for a chronic pain management program from M.D. dated 08/25/10

A reconsideration request from M.S., L.P.C. dated 09/08/10

A letter of non-certification, according to the ODG, from Ph.D. dated 09/23/10

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

PATIENT CLINICAL HISTORY [SUMMARY]:

Therapy was performed with Ms. Mr. and Mr. on 12/30/09, 01/08/10, 01/12/10, 01/15/10, and 01/21/10. On 01/12/10, Ms. recommended six sessions of individual psychotherapy. An FCE with Dr. on 07/14/10 indicated the patient functioned at the medium physical demand level and a work hardening program was recommended. On 07/14/10, Dr. recommended a chronic pain management program. On 08/25/10, Dr. wrote a letter of non-certification, according to the ODG, for 10 sessions of a chronic pain management program. On 09/08/10, Mr. wrote a reconsideration request for the pain management program. On 09/23/10, Dr. wrote a letter of non-certification for the chronic pain management program.

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

Although it is noted the claimant has not regained his preinjury status despite physical therapy, conservative care, injections, and 20 sessions of a work hardening, program, there does not appear to be a confirmable diagnosis to which one can relate the need for 10 sessions of a chronic pain management program at this time. It was also noted throughout the work hardening team conference notes the claimant missed a week for unknown reasons and had inconsistent attendance. His current physical demand level is medium, which is an improvement from his previous sedentary demand level. The

Official Disability Guidelines (ODG) note that one of the criterion for admittance to a chronic pain management program is motivation to change and willingness to change their medication regimen. There is no documentation that the claimant has motivation to change or a willingness to change his medications, as during his behavioral health evaluation it was noted the MMPI-2 was invalid, which was attributed to a distinct pattern of over reporting symptoms. An additional criteria of the ODG is that previous methods of treating chronic pain have been unsuccessful; however, it is unclear at this time if the work hardening program was truly unsuccessful, as he had multiple absences and inconsistent attendance. Another criteria is identifying negative predictors for success. One of these is elevated pretreatment levels of pain. The claimant's current pain level is 9/10 despite treatment and medications. Therefore, the requested chronic pain management program five times a week for two weeks is neither reasonable nor necessary per the documentation provided and the ODG. Therefore, 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 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

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)**