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Notice of Independent Review Decision

DATE OF REVIEW: 12/02/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten days 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.

Ten days of a chronic pain management program - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Chest x-rays dated 11/22/05 and interpreted by M.D.
A blood bank collection note with a collection date of 11/22/05

Portable lateral lumbar x-rays dated 11/23/05 and interpreted by Dr.

A History and Physical Examination at Medical Center dated 11/23/05 from M.D.

An operative report from Dr. dated 11/23/05

A pathology report dated 11/23/05 and interpreted by M.D.

Portable chest x-rays performed on 11/26/05 and interpreted by M.D.

A discharge summary dated 11/28/05 from Dr.

X-rays of the lumbar spine dated 12/16/05 and interpreted by M.D.

X-rays of the lumbar spine and bilateral hips dated 08/29/06 and interpreted by M.D.

An initial pain consultation with M.D. on 10/27/09

Evaluations with Dr. dated 01/05/10, 03/22/10, 06/01/10, 09/28/10, and 04/19/11

A request for psychological evaluation and three hours of psychological testing from Dr. dated 07/21/11

An information sheet on the patient from Health Services dated 07/25/11

A letter of medical necessity from Dr. dated 07/25/11

A Physical Performance Evaluation (PPE) performed on 10/11/11 and interpreted by P.T.

A Psychosocial Evaluation dated 10/11/11 at Health Services with L.C.S.W.

A Request for 10 Day Pain Management Program dated 10/11/11 from M.D.

Ph.D. provided a review determination for dated 11/03/11

A Letter of Appeal from Dr. dated 11/07/11

Ph.D. also provided a review determination for dated 11/14/11

A Letter of Appeal to IRO dated 11/14/11 from Dr. An undated Vocational Training Plan from Health Services

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

Dr. performed a bilateral redo central decompressive laminectomy at L5-S1 with bilateral foraminotomies with excision of recurrent disc herniation at L5-S1, additional bilateral central decompressive laminectomy at L4-L5 with bilateral foraminotomies and excision of the central disc herniation, bilateral lateral transverse process fusion at L4-L5 and L5-S1 with cages, and repair of dural tear on 11/23/05. X-rays on 08/29/06 revealed status post L4-S1 fusion and the left hip films revealed arthroplasty that had an expected post surgical appearance. On 01/05/10, Dr. evaluated the patient for his continued low back pain with radiating pain to the left hip. He had some decreased sensation in the L4-L5 dermatomes in both lower extremities. Voltaren gel was prescribed. The patient informed Dr. on xx/xx/xx that he had fallen recently, as his left leg gave out when he was going down some stairs. Rybix and physical therapy were prescribed. On 04/19/11, Dr. recommended a TENS unit and continued aquatic therapy. The patient underwent a PPE on 10/11/11 and it was felt he was an excellent candidate for participation in a pain program to include aquatic therapy. On 10/11/11, the patient also underwent a psychosocial evaluation with Ms. who recommended the patient attend a pain program. Dr. performed a patient

assessment on 10/11/11, which was also a request for 10 days of a pain management program. It was noted his medications would be titrated as a portion of the program. On 11/03/11, Dr. provided an adverse determination for the requested 10 sessions of a pain program. Dr. wrote a letter of appeal for the pain program on 11/07/11, stating the ODG supported such use of a functional restoration program/chronic pain program for the patient. On 11/14/11, Dr. Dr. for provided another adverse determination for the 10 requested sessions of a pain program. Dr. addressed a letter of appeal to the IRO on 11/14/11, requesting approval of the 10 sessions of the functional restoration program.

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

Ten days of a chronic pain management program are neither reasonable nor necessary. The patient's most recent interventions are performed in 2005. In 2009, the patient was seen by Dr. a pain management physician. The patient refused an appropriate work-up because he did not receive prescriptions for pain medication. There is no evidence that the patient has been working with Dr. stating in June of 2010 that the patient was unable to return to work. There was no indication that he had worked even before 01/05/10. This is clearly one of the criteria for a pain management program in that the patient is likely to return to work or has a return to work plan in place. It does not appear based on the documentation that he is likely to return to work. Addiction issues/medication use have not been addressed as per the Official Disability Guidelines (ODG).

The negative predictors of success have not been outlined. There is no performance based Functional Capacity Evaluation (FCE). The injury is xx years old and the patient has been in chronic pain for many years. There is no indication that attending a chronic pain management program will make a significant change to his outcome. For those reasons, the ODG criteria are not met. As a board certified orthopedic surgeon, having reviewed the medical documentation provided and the utilization review notices, the requested 10 sessions of a chronic pain management program would not be appropriate 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)