

Wren Systems

An Independent Review Organization
3112 Windsor Road #A Suite 376
Austin, TX 78703
Phone: (512) 553-0533
Fax: (207) 470-1064
Email: manager@wrensystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/05/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic Pain Management 5xWk x 2Wks

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

M.D., Board Certified 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

Utilization review findings 09/06/11

Utilization review findings 10/03/11

Response 11/15/11

Office notes Dr. 04/22/08, 05/26/09, and 11/24/09

Office notes Dr. 06/28/10-07/21/11

Psychological evaluation 08/10/11

Work hardening program daily notes 03/19/07-04/04/07

Chronic pain management progress notes 10/03/07-10/25/07

Designated doctor evaluation Dr. 12/22/08

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained an injury on xx/xx/xxx while working as . She was transferring a slipped. The claimant tried to break the fall and felt popping in her low back. She has been treated with physical therapy, TENS unit, exercise therapy, stretching, heat/ice, topical analgesics, injections, surgery x 2, work hardening, individual counseling, and chronic pain management program. Current medications were noted to include Hydrocodone 10/325 po bid, and Amitriptyline 25 mg po at night. Per the request for chronic pain management program for dates of service beginning 08/29/11-09/29/11 it was noted the claimant is currently off work and still unable to return to work due to physical disabilities, depression, and anxiety.

A utilization review performed on 09/06/11 noted the claimant was last seen on 08/24/11, which showed the claimant is currently off work and still unable to return to work due to physical disabilities, depression and anxiety. Medical records reflected that the claimant has had previous chronic pain management program. It was noted that current evidence based

guidelines do not recommend reenrollment and repetition in same or similar rehabilitation program for same condition or injury. A utilization review performed on 10/03/11 noted the claimant sustained an injury on xx/xx/xx and continues to experience back pain. Recent medical submitted for review dated 08/10/11 did not contain comprehensive objective findings such as detailed orthopedic neuromotor examination to substantiate the medical necessity of the requested service. There was no objective documentation of failure of trial of conservative treatment such as physical therapy and pharmacotherapy. Moreover, it is noted the claimant sustained injury more than 5 years ago. There is conflicting evidence that chronic pain management program provide return to work beyond period of 24 months as per reference guidelines. In such cases, specific short and long term treatment goals that delineate end point of care should be provided for review. In addition, it is noted the claimant has already participated in at least 10 sessions of chronic pain management program per medical dated 10/23/08. Neither reenrollment nor repetition of same or similar rehabilitation program is medically warranted for same condition or injury.

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

The claimant sustained an injury to low back in xx/xx. She is noted to have undergone surgery x 2. She continues to complain of low back pain. The claimant has had extensive treatment including a work hardening program from 03/19/07-04/04/07. The claimant also participated in a chronic pain management program from 10/03/07-10/25/07. As noted on previous reviews, per ODG Guidelines Pain Chapter, at conclusion and subsequently neither reenrollment nor repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, outpatient rehabilitation) is medically warranted for same condition or injury. The claimant has participated in work hardening and chronic pain management, and repetition of chronic pain management is not indicated as medically necessary. Moreover, the guidelines do not support treatment for patients who have been continuously disabled for greater than 24 months. The patient's date of injury is greater than 5 years old. For these reasons, the reviewer finds no medical necessity for Chronic Pain Management 5xWk x 2Wks.

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 KNOWLEDGBASE
- 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)