



7331 Carta Valley Drive | Dallas, Texas 75248 | Phone: 214 732 9359

Notice of Independent Review Decision

DATE OF REVIEW: 5/31/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97799 Chronic Pain Management Program x 80 hours

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

M.D. Board Certified in Occupational Medicine and Urgent Care Medicine

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

Document Type	Date(s) - Month/Day/Year
Notice of Case Assignment	5/11/20XX
IRO Request	05/10/20XX
Utilization Review Agent Determinations	3/10/20XX 3/28/20XX
Employers First Report of injury and Illness	XX/XX/XXXX
Associate statement	XX/XX/XXXX
Provider	12/21/20XX
Bona Fide Job offer Temporary Alternative Duty	9/14/20XX
Emergency Department Reports	
Radiology Report	9/12/20XX
Work Status Report	9/13/20XX-4/19/20XX
Urgent Care Evaluation	9/12/20XX 9/17/20XX
Prescription for Relafen 500mg	9/13/20XX
Clinic Radiology Report	9/20/20XX



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Progress Notes	9/20/20XX-3/21/20XX
M.D. Initial Consultation	9/20/20XX-11/05/20XX
Prescription and Medical Necessity	10/18/20XX-1/03/20XX
MRI Lumbar Spine	10/14/20XX
M.D. Prescription for Ultram 50mg, Flexeril 10 mg Prescription for Ultram 50mg, Flexeril 10mg, Motrin 600mg Progress Notes	12/1/20XX 1/3/20XX 2/03/20XX-4/19/20XX
M.D. Electromyographic Examination	1/04/20XX
Functional Testing Work Capacity Evaluation	2/24/20XX
Report of Medical Evaluation	4/12/20XX
Designated Doctor Evaluation	4/11/20XX
Documentation and determination Letters Behavioral Evaluation report	2/11/20XX
Utilization Review Agent Review Outcome	3/10/20XX-3/28/20XX

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a XX year-old company employee who reportedly strained her lumbar spine approximately XX ½ months ago, when she slipped on some algae.

Thus far, she has been treated with the following: various analgesic medications; 15 sessions of physical therapy; chiropractic manipulations; a number of home DME devices, including a TENS unit, pillow, gelpack, brace, etc.; extensive periods of total temporary disability; consultation with multiple specialist physicians; and was ultimately declared at Maximum Medical Improvement by a Designated Doctor on 11/5/20XX.

An MRI of the lumbar spine revealed a 3 mm disc bulge at L4-L5, impinging upon a nerve root an EMG of the bilateral lower extremities that was negative for radiculopathy but positive for superficial peroneal neuropathy. She was given an offer of modified work but has reportedly not returned to work as of 2/24/20XX.

Her treating physician, Dr., has requested an outpatient 80 hour pain management program.

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

The proposed 80 hour program is hereby CERTIFIED. This request is supported by the Official Disability Guidelines, which state that pain management programs: “Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in “Delayed recovery.”

Patient meets the criteria for admission to a pain management. She is on a number of analgesic and adjuvant medications; she has failed to return to work; she continues to



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report chronic low back pain; she has developed co-morbid depression; and has exhibited a delayed recovery, some XX months removed from the date of injury.

Patient has failed all prior treatments offered to her, including medications, physical therapy, TENS Units, DME supplies and chiropractic manipulations. The pain management program is the next appropriate step in her treatment.

As noted in the guidelines, patient has had a thorough and complete diagnostic work-up, with plain films, MRI and EMG.

Dr.'s request for an 80 hour trial of a pain management is of a duration that is consistent with the guidelines. For all of the reasons above, the request is hereby CERTIFIED.

REFERENCES

ODG back chapter chronic pain programs.

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